

**UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA**

MIAMI DIVISION

CASE NO. _____

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey
Limited Liability Company, d/b/a
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois
Corporation, d/b/a
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,
an Illinois Corporation, d/b/a
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

_____ /

EXHIBIT A
TO COMPLAINT FILED
FEBRUARY 28, 2023

Clinical Approach to Fishhook Removal

Anthony G. Stanley, MD

Jorge Murillo, MD

Abstract

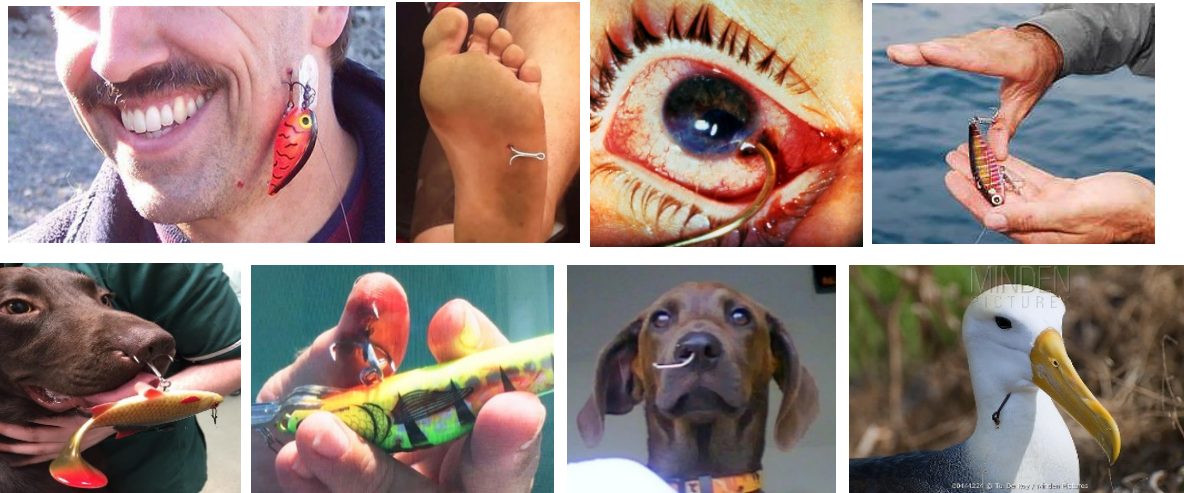
Fish hook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care and urgent care facilities. Fish hook injuries commonly occur in those who participate in the sport or past time of fishing with a rod and line known as 'Angling' (photo1). There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands 1. What has



been seldomly recognized is the, occurrence of injury to bystanders, accompanying pets and animal wildlife. These types of injury are referred to as collateral damage as noted in the Trauma Gallery (photo 2). Studies show that the Emergency Department is the site for 28% of all acute care visits in the United States 2. How common is a fish hook injury? This is a commonly asked question, and very little national data exist on this specific type of injuring. Occurrence of injury is an area where more clinical research needs to be performed. Fish hook injuries that are not treated in the field will present to the ER, urgent care or ambulatory care centers. When these injuries present to the health care facilities, "there is often, office pandemonium once the receptionist gives notification of a fish hook injury in the waiting room". Besides the high anxiety felt by the patient, the staff also goes through an equivalent experience. There is disruption in continuity of care of patients already in the treatment area, due to staff frantically making phone calls searching for a fish hook removal device. Currently there are no medical fish hook removal system established. In addition to locating a wire cutting tool for removal, the physician must be well versed in the anatomy of fish hooks and knowledge of the concepts of how to safely remove this type of foreign body. Often because of unavailability of established medical fish hook removal system(s), clinician's lack of removal experience, many of these cases are simply screened by the nurse and doctor then sent to the ER for removal. This leads to loss of revenue by the referring facility, and causes the patient to experience additional pain, suffering and subsequent dissatisfaction rating on satisfaction surveys. Fish hook removal is a procedure comparable in difficulty to laceration repair of the skin with proper equipment. The fish hook removal system can be either disposable or a reusable sterile device similar to, the standard suture tray. This article will review the clinical approach to evaluation and removal of fish hooks. A well-versed doctor should be familiar with the anatomy of the fish hook (figure1), the anatomy of injured area and versed in common techniques used to remove fish hooks in a timely and safe manor with minimal trauma, to minimize the patients suffering3. By having

an established medical removal system, safety and patient care experience will be enhanced in several areas monitored by Centers for Medicare and Medicaid (CMS). The confidence of the doctor, availability of the removal system, gives the patient assurance they are in great hands and reduces anxiety with resultant improved patient experience, there is also benefits of seeing reduced registration time to departure time, and increased patient satisfaction scores.

(Photo 2) Trauma Gallery



This article provides a concise guide to performing the six most common techniques of fishhook removal and injury management. The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the discretion of the provider. Tetanus status should be assessed and Td or Tdap administered if needed with age appropriateness as per established guidelines.

Anatomy of the Fish Hook

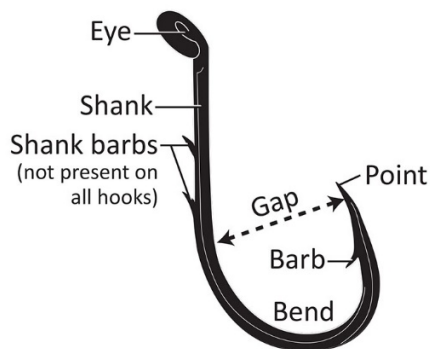
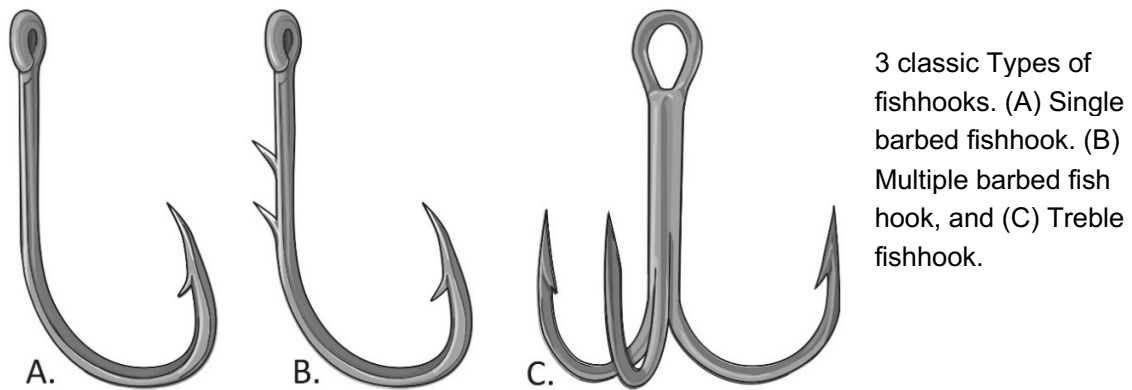


Figure 1

There are 3 classic types of fishhooks available (single barbed, multiple barbed and treble) (figure 2). Common fish hook descriptive features are the following. The point is sharp end that penetrates the fish's mouth or skin. The eye connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The gape or gap describes the distance between the shank and the point. When examining, it is important to note if the fishhook is single barbed, multiple barbed or treble. Also note the number

and location of the barbs, these details will help determine the best removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.

Figure 2 (Classic types of fish hooks)



Patient Evaluation

After obtaining a history of the injury, vital signs, a quick survey of the wound and surrounding structures should be made. A good physical exam is always indicated before removal. Inspect distal and proximal to the injury site. Access for deep injury involving penetration to tendons, nerves and bone. Radiographs are seldom needed but, may aid in determining the type of fishhook and the depth of penetration. Most fishhook injuries are penetrating soft tissue injuries of the hand, face, head or upper extremity but can involve other body part (photo 3). Injuries usually do not involve deeper tissue structures because of the linear forces applied along the fishing line to the curved shape fishhook that brings the point parallel to the skin and keep it from deep penetration⁴. Any eye injury penetrating wounds should be stabilized and transported to the nearest ER for urgent ophthalmology consultation. Remember all wire cutters have a limit of cutting capacity. In cases involving larger fish hooks, the patient may have to be referred to the ER/ Hospital where larger surgical cutting devices are available ie bolt cutter or an extensive surgical procedure may be required.



Photo 3 (X-Ray)

Principles of Removal

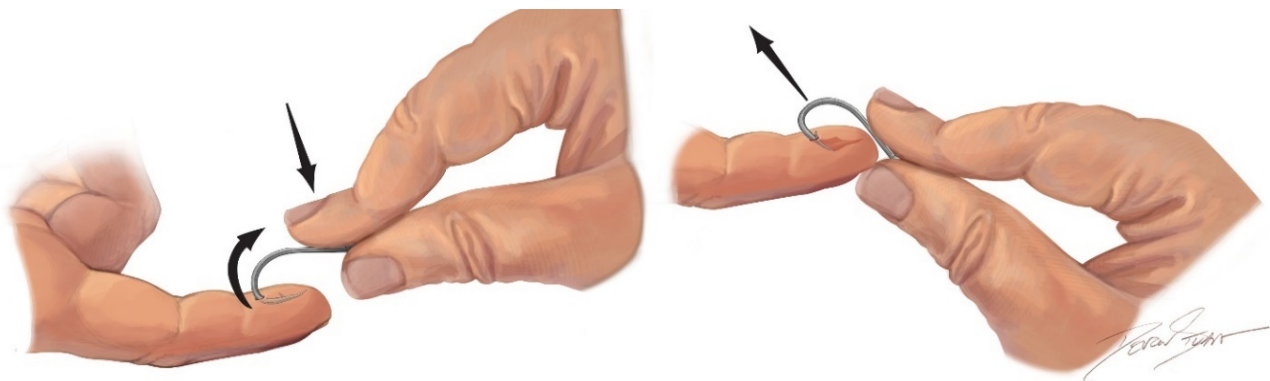
The 6 most common techniques for the removal of fishhooks are: Retrograde, String-Yank, Needle Cover, Barb Crush, Cut It Out and lastly, Advance and Cut. Each method and some modifications to these techniques are described in detail in this article. The method selected to remove an embedded fishhook is usually based on the judgment of the physician, the anatomic location of the injury and the type and anatomy of fishhook. Before you get started make sure that you have of a fish hook removal system. This at minimal will require a wire cutter, hemostat or needle driver, gloves, wound cleanser, protective eyewear (goggles or face shield) and local anesthetic.

The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank methods). Often times multiple techniques must be attempted before the fishhook is successfully removed.

In the clinical setting local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, Hexachlorophene solution or if not available use soap and water before attempting removal of the fishhook. Local anesthesia typically Lidocaine 1% (Xylocaine) without epinephrine, A nerve block or regional block may also be required depending on the injury site. Hooks with more than one point like the treble fishhook, should have the free barbs taped or cut to avoid receiving additional embedded puncture wounds during the removal procedure. All items attached to the hook (i.e., fish line, bait and the body of the lure itself) should be removed. The physician and bystanders should take care not to be struck by the hook during removal. Anyone assisting with the procedure should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the String-Yank method and Advance and Cut method.

1 Retrograde Technique

Retrograde technique is considered the simplest of the removal techniques and has the lowest success rate. It works well for barbless and superficially embedded hooks. Downward pressure is applied to the shank of the hook. This maneuver pushes the hook deeper into the tissue bed and dislodges the barb, from the resting tissue site. The hook can then be backed out of the skin along the path of entry (Figure



3). If there is any resistance or snagging sensation of the barb during the procedure consider an alternative removal method. Figure 3 [Retrograde Technique Diagrams]

Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry.

2 String-Yank Technique

The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires anesthesia. This technique generally works best when removing fishhooks of small and medium size hooks. This technique should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and parts of the body that are not fixed (lips, nose, eye lids, ears) (Photo 4). It has been recognized that traditional counting 1,2,3, go (to give a reference point in time to start) prior to performing a yank-pull attempt, causes most patients to assume a flexed posture, which can cause more damage during the course of pulling. Physicians should be familiar with the concepts of this method. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material: heavy suture cord, or 20 to 30 lbs. test fishing line, can be used. Wrap and position the string material around the midpoint of the bend in the fishhook, to keep the string in a fixed position, use a simple knot such as a Larks Head knot (figure 5). Wrap the free ends around the index finger of the free hand.

Photo 4



A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft. The involved skin area should be well stabilized against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (figure 6A). Fishhooks extracted with this technique will come out with significant velocity, so the physician and bystanders should remain out of the line of flight and wear protective eye wear (goggles or face shield). Caution should be taken when performing the yank procedure. Keep in mind Newtons 3rd Law of Motion 5. For every action there is an equal and opposite reaction. This is true when pulling, there is an equal and opposite force. If there is laxity in the parallel pulling force, the hook can come out of its original position and be forcefully pulled back and be embedded into a new location (See Figure 6-B).

Figure 5 (Larks Head Knot Diagrams)

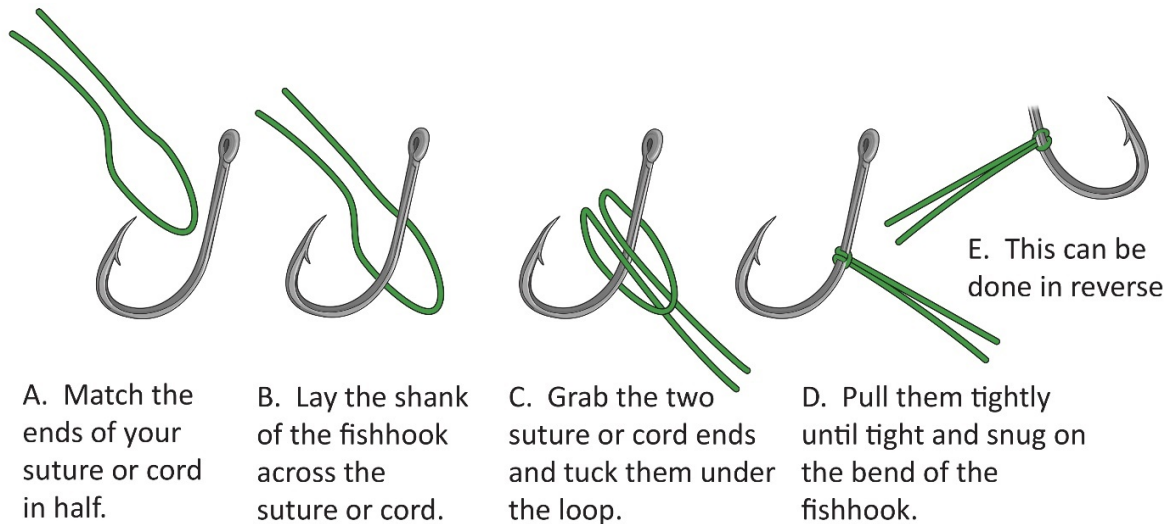
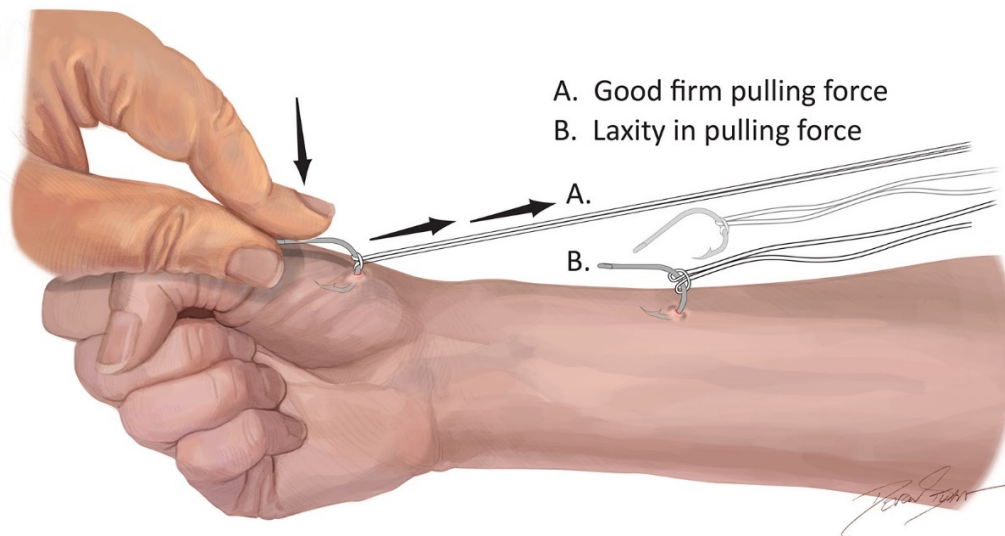


Figure 6 (String Yank Diagrams)

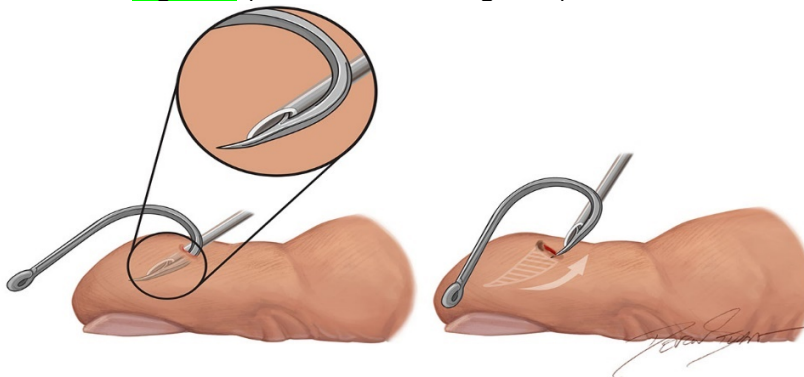
String-yank method. (A) Tie a string using a Larks Head Knot around the midpoint of the bend in the fishhook (figure 6). (B) Depress the shank of the fishhook against the skin. (C) Press firmly and quickly yank/ pull on the string while maintaining continued pressure to the shank of the hook.



3 Needle Cover Technique

The needle cover technique requires great dexterity on the part of the physician and a little luck. It works well for the removal of large hooks with single barb, and when the point of the fishhook is superficially embedded in the skin (surface). After standard wound prep and local anesthesia, a 16-18-gauge needle is advanced along the wound entrance of the fishhook (figure 7). The direction of insertion should be parallel to the shank. The bevel should point toward the inside of the curve of the fishhook, enabling the needle opening to cover over (capping off) the barb. It is important to have the bevel pointed in the correct direction as shown so that the leading edge of the needle matches the angle of the fishhook barb. Advance the fishhook to disengage the barb, then pull and wiggle it so that the point enters the lumen of the needle. Once covered back out the fishhook (similar to the retrograde technique), taking care to move the needle along the entry point of the fishhook.

Figure 7 (Needle Cover Diagrams)



Needle cover method. (A) Advance a 16-18-gauge - needle along the fishhook until the needle opening covers or caps, the barb. (B) The fishhook and needle are then pulled back and removed as a single unit.

A modification of this technique involves sliding a # 11 scalpel blade along the wound to the point of the fishhook. The fishhook may then be backed out thru the track of the incision line.

4 Barb Crush Technique

The Barb Crush technique is considered another modification of the Retrograde Technique. It has a higher success rate. Often there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fish hook (shank). Using a pair of pliers or sturdy Hemostat you can repeatedly crimp down, and crush the fishhook barb flat using the powerful jaws of your device. Carefully smooth all rough edges, and pull gently backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (Figure 8).

Figure 8 (Barb Crush Diagrams) Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes.



5 Cut It Out Technique

The cut it out technique useful in penetrating fish hook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fish hook injuries penetrating the sclera or cornea [6](#). However, this should be a procedure of last resort in the ambulatory care setting, when there is no wire cutting device available and there is an urgent need to remove the fish hook ([figure 9](#)). This technique is best conducted in an area of superficial penetration, no major surrounding neuro vascular structures or tendons present. To perform you simply take a hemostat and pull up gently on the shaft of the hook, in a vertical direction ([see figure9](#)). Next take a scalpel, preferable a standard #11 blade type and gently cut along the shaft of the distal end of the fish hook toward the proximal end with the barb. The hook can be then extracted and discarded. This technique consequently causes lots of tissue damage and the resultant scar will likely have a jagged wound edge appearance.

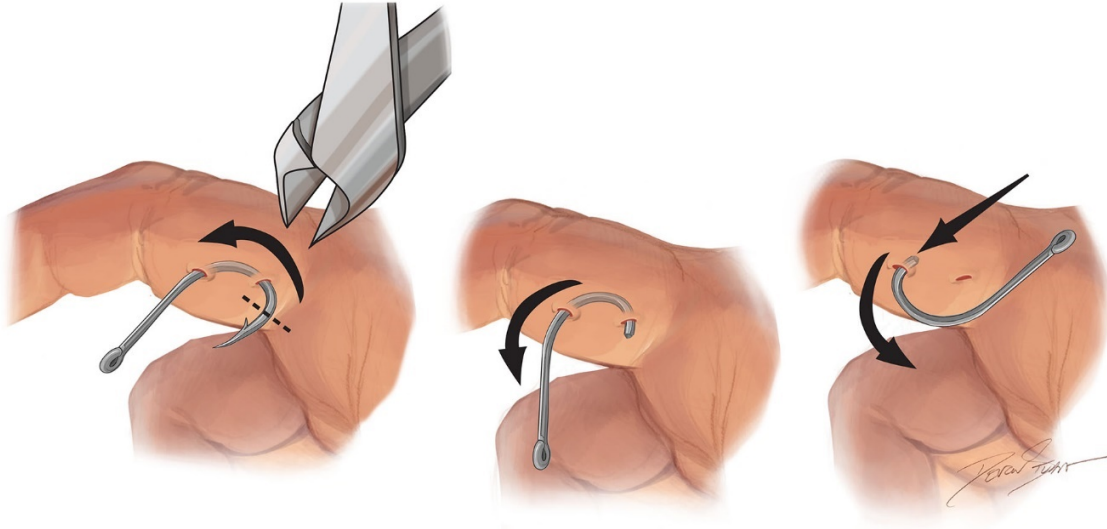
Figure 9 (Cut it out Diagrams)

Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment.

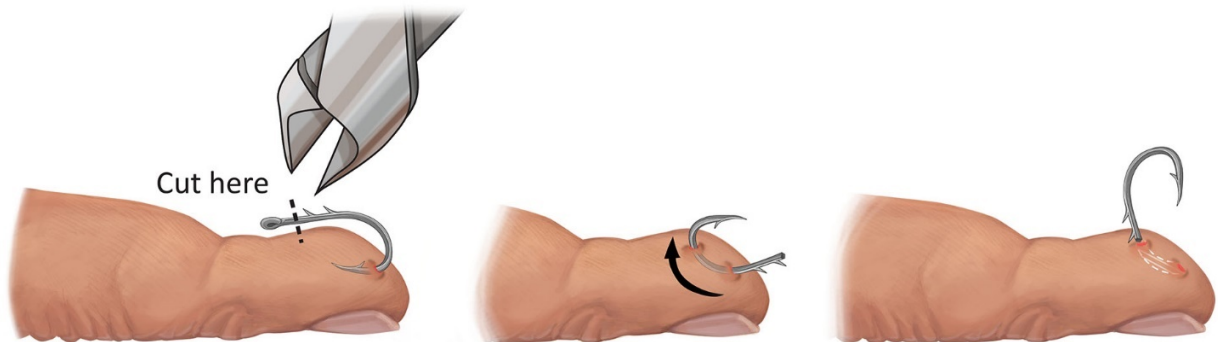


6 Advance and Cut Technique

One advantage of this traditional method of fishhook removal is that it has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The **Advance and cut technique** is most effective when the point of the fishhook is located near the surface of the skin⁷. It involves two methods of removal: one for single-barbed fishhooks (Figure 10) and one for multiple-barbed fishhooks (Figure 11) where the non-embedded hooks are cut off prior to attempting removal. Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin, alternatively a digital or regional block may be appropriate for various body site injuries⁸. Using a Hemostat or needle driver. Using a strong grip and twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note, is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fish hook completely clears the skin surface, cut it with a medical wire cutter or another cutting tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fish hook fragments fly off with massive force and cause bodily injury. The Advance and Cut Technique is most universally accepted in the Urgent Care, ambulatory care and ER settings. This procedure is the most familiar to providers and least anxiety producing for the general public. If by chance the fish hook has several barbs on the shaft the distal end (eye) should be cut off with a cutter and the proximal end with the hook is pulled forward through the exit wound (figure 11). A surgical fishhook removal device, based on this technique is available (SMD, INC, Miami Beach, Florida)⁹. Remember all wire cutters, have a limit of diameter cutting capacity and in cases involving larger fish hooks, they may have to be referred to the ER or Hospital where a bolt cutter or surgical procedure may be required.

Figure 10 (Single Barb Advance and Cut Diagrams)

Advance and cut method: single-barbed fishhook. (A) Advanced the fishhook through the skin creating an exit wound. (B) Cut off the barb of the fishhook (C) back the remaining fishhook out the entry point.

Figure 11 (Multiple Barbs: Advance and Cut)

Advance and cut method: for multiple-barbed fishhook. (A) Advanced the fishhook through the skin creating an exit wound. (B) Cut the eye of the fishhook off and (C) Pull the remaining fishhook forward through the exit wound created by advancing the point through the skin.

Post-Removal Wound Care

After removal of the fish hook, the wound should be irrigated thoroughly with normal saline. All debris and foreign bodies present in the wound should be removed. After the procedure is completed, the wound should be covered with antibiotic ointment (Mupirocin) and a sterile dressing. Wound care should include routine irrigation, cleansing (betadine), application of antibiotic ointment and dressing change on a daily basis or every other day. Observations

should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water 2 to 3 times a day until healing is observed.

Infections after fishhook removal are uncommon therefore, routine use of antibiotics for uncomplicated superficial skin injuries are not indicated ¹. If there is deep tissue injury in anatomical areas with higher risk for infection such as earlobes, fingertips or tendons, antibiotics should be prescribed empirically.

Infections are commonly caused by *Staphylococcus aureus* (*S. aureus*) and *Streptococcus pyogenes*, which are normal flora of the skin. Once skin injury occurs, these bacteria can be introduced to the wound and can cause an infection.

If the patient has risk factors for **methicillin-resistant Staphylococcus aureus (MRSA)** infection such as history of skin abscess, furuncles, MRSA colonization, frequent exposure to antimicrobial agents, inability to maintain personal hygiene, sharing personal items (i.e. razors, towels, sports equipment, etc.), skin injury, living in crowded housing conditions or in a community where > 15% of *S. aureus* isolates are MRSA, then drugs like Clindamycin (300 – 450 mg PO every 6-8 hours) or the combination of Amoxicillin (875 mg PO every 12 hours) and Trimethoprim-Sulfamethoxazole (1 DS tab PO every 12 hours) or Doxycycline (100 mg PO every 12 hours) is recommended ¹⁰.

If risk factors for MRSA are not present, treatment should cover **Methicillin-susceptible Staphylococcus aureus (MSSA)** and Group A *Streptococcus*. A first-generation cephalosporin like Cefadroxil (500 -1000 mg PO every 12 hours) is recommended, for better compliance other cephalosporins like Cephalexin (first generation) or cefuroxime (second generation) can also be used. In cases of anaphylactic reaction to penicillin, Clindamycin should be the drug of choice ¹¹.

In cases of fishhook exposure and contamination of freshwater or seawater with infectious agents like *Aeromonas*, *Edwardsiella*, *Erysipelothrix* and *Vibrio vulnificus* should be covered empirically. In this situation, the recommendation is Cefadroxil or Clindamycin plus a quinolone such as Levofloxacin (750 mg PO every day) in case of freshwater exposure. If the exposure is to seawater, then Doxycycline should be added for coverage against *Vibrio* species.

Duration of therapy should be 3 to 5 days. Patients who are prescribed antibiotics should be scheduled for follow up 2 to 3 days after the initial visit for evaluation of possible infection. Patients should also be evaluated for tetanus prophylaxis. Tetanus-Diphtheria or Tetanus-Diphtheria-Pertussis (Td or Tdap) vaccine should be administered if there is a history of less than 3 doses or unknown doses of tetanus toxoid administration. If last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.

Conclusions

Fish Hook injuries can occur at any time, during angling, commercial fishing or simply cleaning out the garage. In this era of heightened quality of care as measured by emphasis placed on shorter arrival to discharge times, patient satisfaction and patient outcome, there is a need to establish a basic minimal procedural understanding by all healthcare providers involved in ambulatory care, urgent care and emergency rooms for quick assessment and swift removal of fish hooks. This an area where risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method. Always consider starting with the simpler removal techniques (Retrograde, Needle Cover) prior to the more robust methods mentioned in this article. There is a need to establish a standard fish hook removal system that is as universal as the suture tray. Containing a medically approved cutting device, along with hemostat, protective eye wear, and other supportive care supplies. By being prepared for this inevitable occurrence the patient can be seen in a timely manner, experience minimal suffering and anxiety. Health care Institutions now realizing reimbursements are tied to the quality of care that is given ², should make it easier to appreciate this specialized procedure by having an established protocol, provider training and fish hook removal systems located in every ambulatory health care facility supply room in close proximity to the laceration repair kit.

The Authors

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URGENT CARE ASSOCIATION, INC., an Illinois
Corporation, d/b/a
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,
an Illinois Corporation, d/b/a
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

_____ /

**EXHIBIT B
TO COMPLAINT FILED
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JUNE 2021

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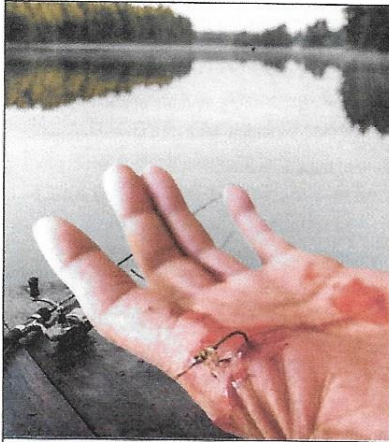


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CLINICAL

13 An Urgent Care Approach to Fishhook Removal

Gone fishin' usually signals a blissful experience in nature—until fishhook meets human flesh, at least. When patients present with a sharp, barbed metal object embedded in one body part or another, you'll need a sound understanding of the type of hook you're dealing with, the corresponding proper technique for removal, and what the next steps should be.

Anthony G. Stanley, MD and Jorge Murillo, MD

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The patient's accounting of what brought them to your urgent care center is the foundation of the history. However, falling victim to anchoring bias could have devastating consequences.

Ryan Hagan, PA-C and
Christina Gardner, DHSC, MBA, PA-C

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Aimy Patel, MD; Jennifer Johnson, MD;
Brian R. Lee, PhD, MPH;
Amanda Montalbano, MD, MPH

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Jordan Wackett, MD, MPH, Joshua Kornegay, MD, and Craig Rudy, MD

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Identifying the type of seizure and causes of fever are the essential first steps.

Tiffany Addington, MD

NEXT MONTH IN JUCM

The sight of blood is always unsettling to the patient and their loved ones. While it's likely to be less disconcerting to healthcare professionals, bleeding without an obvious cause is concerning even when the presentation is something as common as epistaxis. Vital signs, location of the bleeding, and patient history are essential to understanding the etiology. Familiarity and comfort with certain procedures are necessary for a positive outcome. Reading the cover article in the July/August issue of JUCM will help you feel confident that you'll be prepared.

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Clinical

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An Urgent Care Approach to Fishhook Removal

Urgent message: While fishhook injuries are common in urgent care centers located in or near recreation areas, especially during vacation season, their untimely presentation can cause pandemonium in the office. Management requires a thorough understanding of the mechanism of injury, the type of hook involved, and proper technique for removal.

ANTHONY G. STANLEY, MD and JORGE MURRILO, MD

Citation: Stanley AG, Murrilo J. An urgent care approach to fishhook removal. *J Urgent Care Med.* 2021; 15(9):13-18.

Introduction

Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and urgent care facilities, especially among those who participate in the sport of fishing with a rod and line (or “angling”). There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands.¹ What has been seldomly recognized is the occurrence of injury to bystanders, as well as to accompanying pets and wildlife. These types of injury are referred to as *collateral damage*.

U.S. data on actual incidence of fishhook injuries are scarce, as many such injuries are treated in the field without attention from a healthcare provider. However, the presumption is that patients who seek medical care do so in the emergency room, an urgent care center, or in an ambulatory care center. (The emergency department is the site for 28% of all acute care visits in the United States.²) From this author’s experience, pandemonium commences as soon as front desk personnel in the urgent care center announce there’s a fishhook injury in the waiting room.

Fishhook removal is a procedure comparable in

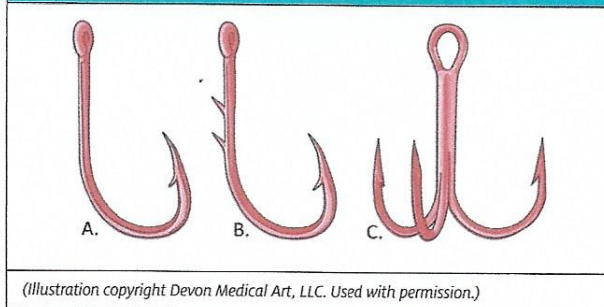


difficulty to laceration repair of the skin with proper equipment. The fishhook removal system can be either disposable or a reusable sterile device similar to the standard suture tray. Here, we review the clinical approach to evaluation and removal of fishhooks, focusing on the six most common techniques of fishhook removal and injury management. To do so, it is essential to understand the anatomy of the fishhook,

Author affiliations: Anthony G. Stanley, MD, Criticare Clinics & Urgent Care, Miami, FL; Baptist Healthcare of South Florida; Stanley Medical Designs. Dr. Stanley holds patents for three medical devices, but has no relevant outside financial relationships with any commercial interests. Jorge Murrilo, MD, FIDSA, FACP, Herbert Wertheim College of Medicine, Florida International University; Baptist Health System of South Florida. Dr. Murrilo has no relevant financial relationships with any commercial interests.

AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

Figure 1. Classic types of fishhooks: A, single barbed fishhook; B, multiple barbed fishhook; C, treble fishhook.



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the injured area, and common techniques used to remove fishhooks in a timely and safe manner with minimal trauma.

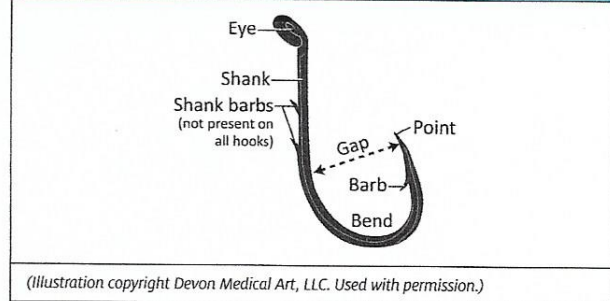
Anatomy of the Fishhook—and Why It Matters

The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the discretion of the provider. Tetanus status should be ascertained.

There are three classic types of fishhooks: single-barbed, multiple-barbed, and treble (Figure 1). There are common features among them, however (Figure 2). In each, the "eye" connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The "point" is the sharp end that penetrates the fish's mouth or skin. The gape or gap describes the distance between the shank and the point.

When examining the patient, it is important to note whether the fishhook is single-barbed or multiple-

Figure 2. Anatomy of the fishhook.



barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.

Patient Evaluation

After obtaining a history of the injury and vital signs, a quick survey of the wound and surrounding structures should be made. Inspect distal and proximal to the injury site. Assess for deep injury involving penetration to tendons, nerves, and bone. Radiographs are seldom needed, but may aid in determining the type of fishhook and the depth of penetration.

Most fishhook injuries are penetrating soft-tissue injuries of the hand, face, head, or upper extremity but can involve other body parts. Injuries usually do not involve deeper tissue structures because of the linear forces applied along the fishing line to the curved shape fishhook that brings the point parallel to the skin and keep it from deep penetration.³ Any eye injury penetrating wounds should be stabilized and transported to the nearest ED.

Bear in mind that the cutting capacity of wire cutters is limited. In cases involving larger fishhooks, the patient may have to be referred to the ED where larger surgical cutting devices are available (ie, bolt cutter or an extensive surgical procedure may be required).

Principles of Removal

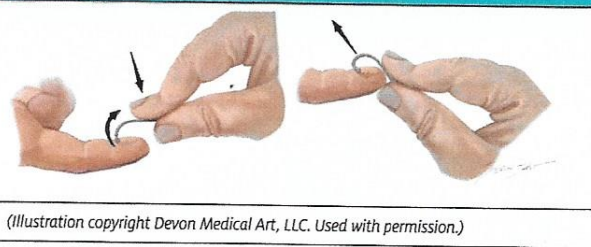
The six most common techniques for the removal of fishhooks are:

1. Retrograde
2. String-yank
3. Needle cover
4. Barb crush
5. Cut-it-out
6. Advance-and-cut

The method selected is based on the judgment of

AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

Figure 3. Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry.



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the provider, the anatomic location of the injury, and the type and anatomy of fishhook. Before you get started make sure that you have of a fishhook removal system. At minimum, this will require:

1. Wire cutter
2. Hemostat or needle driver
3. Gloves
4. Wound cleanser
5. Protective eyewear (goggles or face shield)
6. Local anesthetic

The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank methods). Often times, multiple techniques must be attempted before the fishhook is successfully removed.

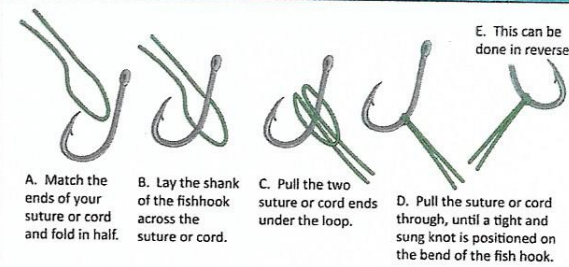
In the clinical setting, local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, hexachlorophene solution before attempting removal of the fishhook. Patients who contact the urgent care center before arrival can be advised to wash the wound with soap and water. Local anesthesia is typically lidocaine 1% (Xylocaine) without epinephrine. A nerve block or regional block may also be required depending on the injury site.

Hooks with more than one point like the treble fishhook should have the free barbs taped or cut to avoid additional embedded puncture wounds during the removal procedure. All items attached to the hook (eg, fish line, bait, and the body of the lure itself) should be removed. The provider and bystanders should take care not to be struck by the hook during removal. Anyone assisting with the procedure should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the string-yank method and advance-and-cut method.

Retrograde Technique

Retrograde technique is considered the simplest of the removal techniques but has the lowest success rate. It

Figure 4. Applying a lark's head knot to a fishhook.



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works well for barbless and superficially embedded hooks. Downward pressure is applied to the shank of the hook. This maneuver pushes the hook deeper into the tissue bed and dislodges the barb from the resting tissue site. The hook can then be backed out of the skin along the path of entry (Figure 3). If there is any resistance or snagging sensation of the barb during the procedure, consider an alternate method.

String-Yank Technique

The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires anesthesia. This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).

The tradition of counting 1,2,3, go (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.

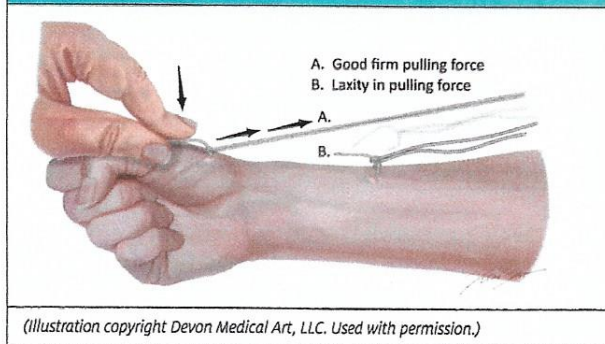
Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position; use a simple knot such as a lark's head knot (Figure 4). Wrap the free ends around the index finger of the free hand.

A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft.

The involved skin area should be well stabilized

AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

Figure 5. String-yank method. A: Tie a string using a lark's head knot around the midpoint of the bend in the fishhook. B: Depress the shank of the fishhook against the skin. Press firmly and quickly yank/pull on the string while maintaining continued pressure to the shank of the hook.



against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (Figure 5A).

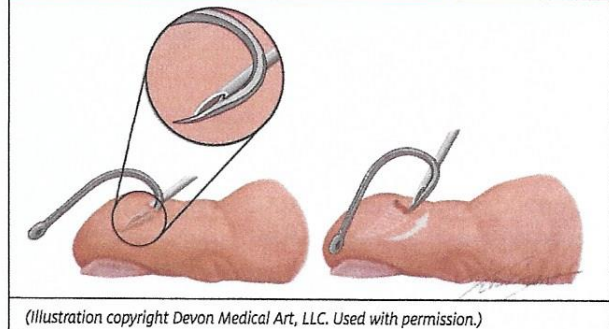
Fishhooks extracted with this technique will come out with significant velocity, so the provider and bystanders should remain out of the line of flight and wear protective eye wear (goggles or face shield). Caution should be taken when performing the yank procedure. Keep in mind Newton's third Law of Motion⁴; for every action there is an equal and opposite reaction. This is true when pulling. If there is laxity in the parallel pulling force, the hook can come out of its original position and be forcefully pulled back and become embedded into a new location (Figure 5B).

Needle Cover Technique

The needle cover technique requires great dexterity on the part of the provider (and a little luck). It works well for the removal of large hooks with a single barb, and when the point of the fishhook is superficially embedded in the skin (surface).

After standard wound prep and local anesthesia, a 16- to 18-gauge needle is advanced along the wound entrance of the fishhook (Figure 6). The direction of insertion should be parallel to the shank. The bevel should point toward the inside of the curve of the fishhook, enabling the needle opening to cover over (capping off) the barb. It is important to have the bevel

Figure 6. Needle cover method. Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps, the barb. The fishhook and needle are then pulled back and removed as a single unit.



pointed in the correct direction as shown so that the leading edge of the needle matches the angle of the fishhook barb. Advance the fishhook to disengage the barb, then pull and wiggle it so that the point enters the lumen of the needle. Once covered, back out the fishhook (similar to the retrograde technique), taking care to move the needle along the entry point of the fishhook.

A modification of this technique involves sliding a #11 scalpel blade along the wound to the point of the fishhook. The fishhook may then be backed out through the track of the incision line.

Barb Crush Technique

The barb crush technique is considered another modification of the retrograde technique, but with a higher success rate.

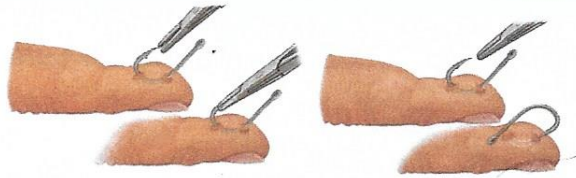
Often, there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fishhook (shank). Using a pair of pliers or sturdy hemostat you can repeatedly crimp down and crush the fishhook barb flat. Carefully smooth all rough edges, and pull gently, backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (Figure 7).

Cut-It-Out Technique

The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.⁵ However, this should be a procedure of last resort in the ambulatory care setting,

AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

Figure 7. Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes.



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when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present.

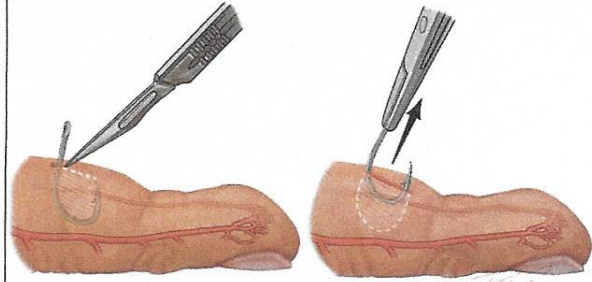
To perform, take a hemostat and pull up gently on the shaft of the hook, in a vertical direction. Next, take a scalpel (preferable a standard #11 blade type) and gently cut along the shaft of the distal end of the fishhook toward the proximal end with the barb. The hook can be then extracted and discarded. (See **Figure 8**). This technique consequently causes lots of tissue damage, and the resultant scar will likely have a jagged wound edge appearance.

Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.⁶ It involves two methods of removal: one for single-barbed fishhooks (**Figure 9**) and one for multiple-barbed fishhooks (**Figure 10**) where the non-embedded hooks are cut off prior to attempting removal.

Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin; alternatively, a digital or regional block may be appropriate for various body site injuries.⁷ Using a hemostat or needle driver, with a strong grip and twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting

Figure 8. Cut-it-out technique. Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment.



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tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury.

The advance-and-cut technique is likely to be the most universally accepted in the urgent care, ambulatory care, and ED settings as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. Bear in mind that all wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients may have to be referred to the ED or hospital where a bolt cutter or surgical procedure may be required.

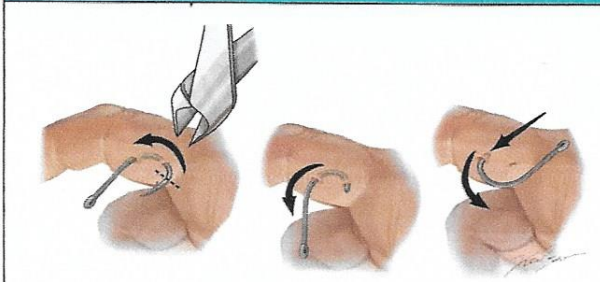
On first glance, it may appear that removing the shank barbs could obviate the need to drag them through the wound. However, it is difficult to stabilize the hook with a hemostat and try to remove the small multiple shank barbs (creating potentially multiple small flying objects as you try to snip them off). Cutting the tail end off, then pulling through, amounts to dragging the shank barbs intact through the tissue plane that has already been cut from the initial puncture wound. This results in less risk of injury to the provider, less anxiety to the patient, and saves time of procedure.

Postremoval Wound Care

After removal of the fishhook, the wound should be irrigated thoroughly with normal saline. All debris and foreign bodies should be removed. Finally, the wound should be covered with antibiotic ointment (mupirocin) and a sterile dressing. Wound care should include rou-

AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

Figure 9. Advance-and-cut technique with a single barb fishhook. Advance the fishhook through the skin, creating an exit wound. Cut off the barb of the fishhook and back the remaining fishhook out the entry point.



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“Risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method.”

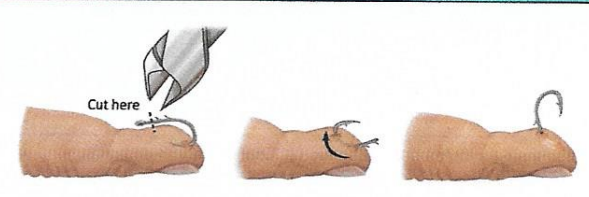
tine irrigation, cleansing (betadine), application of antibiotic ointment, and dressing change on a daily basis or every other day. Observations should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water two to three times a day until healing is observed. Infections after fishhook removal are uncommon.¹ Therefore, routine use of antibiotics for uncomplicated superficial skin injuries is not indicated. For the rare cases in which there is reason for suspicion of infection and antibiotics are prescribed, consideration of coverage for water-borne organisms is reasonable.

Patients should also be evaluated for tetanus prophylaxis. Tetanus-diphtheria or tetanus-diphtheria-pertussis (Td or Tdap) vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.

Conclusion

Fishhook injuries can occur at any time—during angling, commercial fishing, or simply cleaning out the

Figure 10. Advance-and-cut technique with a multiple barb fishhook. Advance the fishhook through the skin creating an exit wound. Cut the eye of the fishhook off and pull the remaining fishhook forward through the exit wound created by advancing the point through the skin.



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garage. There is a need to establish a basic minimal procedural understanding by all healthcare providers involved in ambulatory care, urgent care, and emergency rooms for quick assessment and swift removal of fishhooks. This is an area where risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method. Always consider starting with the simpler removal techniques (ie, retrograde, needle cover) prior to the more robust methods mentioned in this article.

Further, there is a need to establish a standard fishhook removal system that is as universal as the suture tray, containing a medically approved cutting device, along with hemostat, protective eye wear, and other supportive care supplies.

Ensuring there is an established protocol, provider training, and a ready-to-use fishhook removal system on hand (ideally in close proximity to a laceration repair kit) will increase the likelihood of both a positive clinical outcome and high patient satisfaction. ■

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CLINICAL FEATURE ARTICLES

An Urgent Care Approach To Fishhook Removal



Urgent message: While fishhook injuries are common in urgent care centers located in or near recreation areas, especially during vacation season, their untimely presentation can cause pandemonium in the office. Management requires a thorough understanding of the mechanism of injury, the type of hook involved, and proper technique for removal.

Anthony G. Stanley, MD and Jorge Murrillo, MD Citation: Stanley AG, Murrillo J. An urgent care approach to fishhook removal. J Urgent Care Med. 2021;15(9):13-18. INTRODUCTION Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and ...

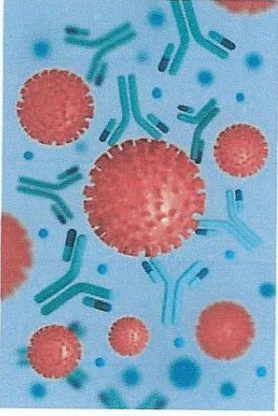
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Outpatient Management Of COVID-19 In The Urgent Care Clinic: Administering Monoclonal Antibodies

Urgent message: The approved use of monoclonal antibodies to treat patients who have COVID-19 may signal a shift from inpatient to outpatient care of infected individuals who do not require hospitalization. Urgent care facilities may be ideally suited to serve as treatment centers and to become destinations of choice for such patients. Lindsey Fish, MD Now that COVID-19 has been with us for over a year, we are in a much different position regarding the treatment of this illness. While many of the initial therapeutics were focused on inpatient, specifically ...

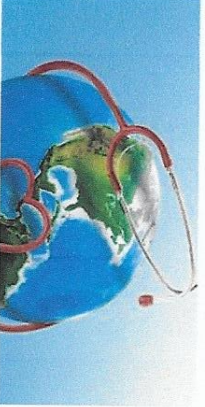
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Pretravel Consultations In The Urgent Care Setting

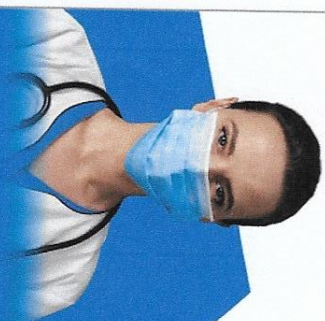


Urgent message: A pretravel consultation assesses the patient's fitness for travel in the context of anticipated risks associated with their journey. This individualized counseling takes into account not just age or destination, but also general health and other factors such as past travel experience. Given the proliferation of single-specialty travel medicine clinics, with appropriate training and preparation, these assessments can easily be



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INTRODUCTION

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U.S. data on actual incidence of fishhook injuries are scarce, as many such injuries are treated in the field without attention from a healthcare provider. However, the presumption is that patients who seek medical care do so in the emergency room, an urgent care center, or in an ambulatory care center. (The emergency department is the site for 28% of all acute care visits in the United States.²) From this author's experience, pandemonium commences as soon as front desk personnel in the urgent care center announce there's a fishhook injury in the waiting room.

Fishhook removal is a procedure comparable in difficulty to laceration repair of the skin with proper equipment. The fishhook removal system can be either disposable or a reusable sterile device similar to the standard suture tray. Here, we review the clinical approach to evaluation and removal of fishhooks, focusing on the six most common techniques of fishhook removal and injury management. To do so, it is essential to understand the anatomy of the fishhook, the

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ANATOMY OF THE FISHHOOK—AND WHY IT MATTERS

The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the *discretion* of the provider. Tetanus status should be assessed and Td or Tdap administered if needed with age appropriateness as per established guidelines.

There are three classic types of fishhooks: single-barbed, multiple-barbed, and treble (Figure 1). There are common features among them, however (Figure 2). In each, the “eye” connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The “point” is the sharp end that penetrates the fish’s mouth or skin. The gape or gap describes the distance between the shank and the point. When examining the patient, it is important to note whether the fishhook is single-barbed or multiple-barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.

Figure 1. Classic types of fishhooks: A, single barbed fishhook; B, multiple barbed fishhook; C, treble fishhook.

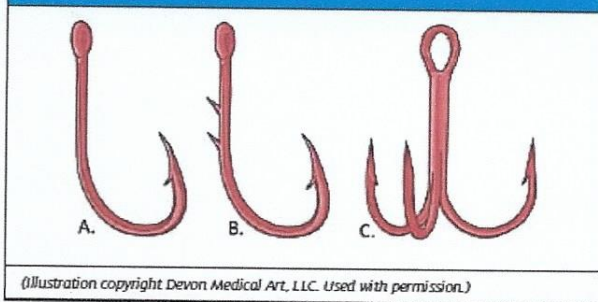
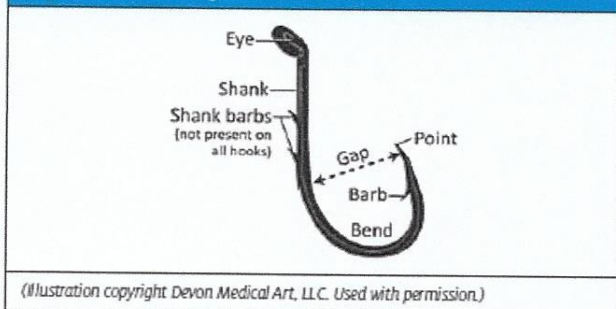


Figure 2. Anatomy of the fishhook.



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After obtaining a history of the injury, vital signs, a quick survey of the wound and surrounding structures should be made. Inspect distal and proximal to the injury site. Assess for deep injury

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PRINCIPLES OF REMOVAL

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6. Local anesthetic

The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank methods). Often times multiple techniques must be attempted before the fishhook is successfully removed.

In the clinical setting, local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, hexachlorophene solution before attempting removal of the fishhook. Patients who contact the urgent care center before arrival can be advised to wash the wound with soap and water. Local anesthesia typically lidocaine 1% (Xylocaine) without epinephrine. A nerve block or regional block may also be required depending on the injury site. Hooks with more than one point like the treble fishhook should have the free barbs taped or cut to avoid additional embedded puncture wounds during the removal procedure. All items attached to the hook (eg, fish line, bait, and the body of the lure itself) should be removed. The provider and bystanders should take care not to be struck by the hook during removal. Anyone assisting with the procedure should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the string-yank method and advance-and-cut method.

Retrograde Technique

Retrograde technique is considered the simplest of the removal techniques but has the lowest success rate. It works well for barbless and superficially embedded hooks. Downward pressure is applied to the shank of the hook. This maneuver pushes the hook deeper into the tissue bed and

dislodges the barb, from the resting tissue site. The hook can then be backed out of the skin along the path of entry (**Figure 3**). If there is any resistance or snagging sensation of the barb during the procedure, consider an alternate method.

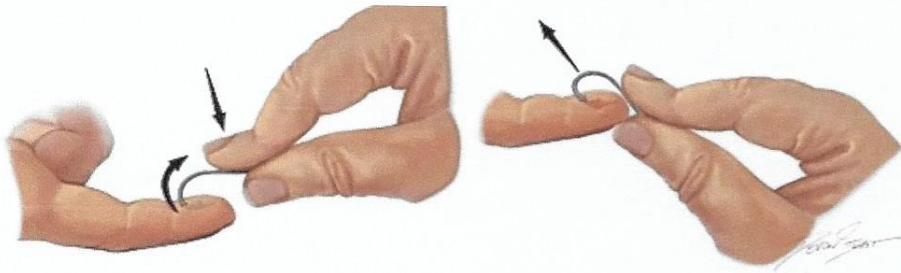


Figure 3. Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

String-Yank Technique

The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires anesthesia. This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).

The tradition of counting *1,2,3, go* (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.

Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position, use a simple knot such as a lark's head knot (**Figure 4**). Wrap the free ends around the index finger of the free hand. A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft. The involved skin area should be well stabilized against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (**Figure 5A**). Fishhooks extracted with this technique will come out with significant velocity, so the provider and bystanders should remain out of the line of flight and wear protective eye wear (goggles or face shield). Caution should be taken when performing the yank procedure. Keep in mind Newton's third Law of Motion⁴; for every action there is an equal and opposite reaction. This is true when pulling. If there is laxity in the parallel pulling force, the hook can come out of its original position and be forcefully pulled back and be embedded into a new location (**Figure 5B**).

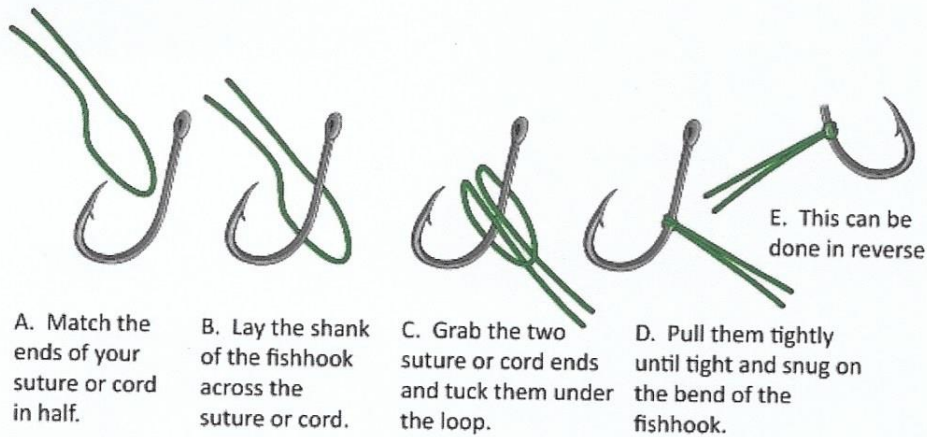


Figure 4. Applying a lark's head knot to a fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

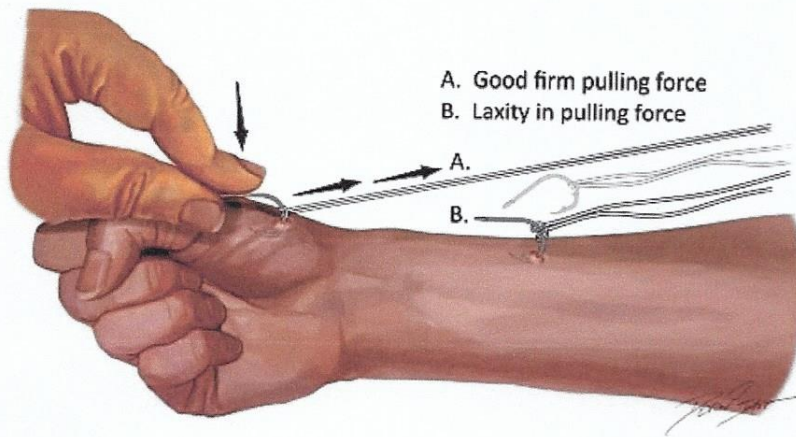


Figure 5. String-yank method. A: Tie a string using a lark's head knot around the midpoint of the bend in the fishhook. B: Depress the shank of the fishhook against the skin. Press firmly and quickly yank/pull on the string while maintaining continued pressure to the shank of the hook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

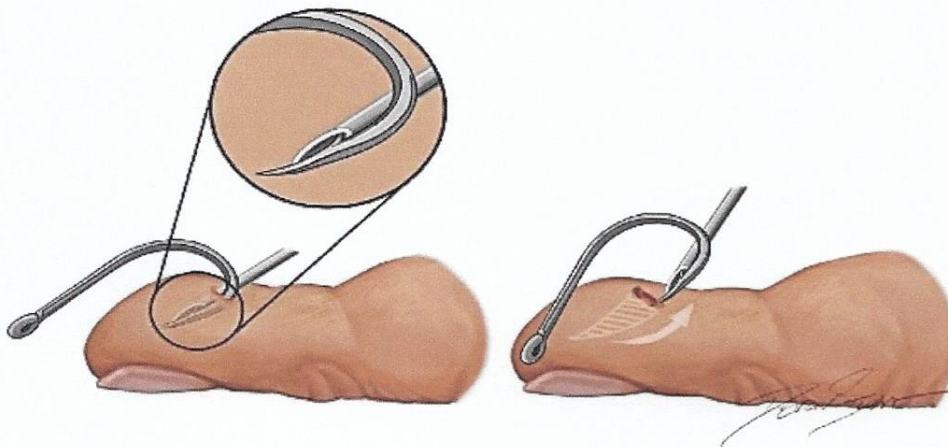


Figure 6. Needle cover method. Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps the barb. The fishhook and needle are then pulled back and removed as a single unit. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

A modification of this technique involves sliding a #11 scalpel blade along the wound to the point of the fishhook. The fishhook may then be backed out thru the track of the incision line.

Barb Crush Technique

The barb crush technique is considered another modification of the Retrograde Technique, but with a higher success rate. Often, there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fishhook (shank). Using a pair of pliers or sturdy hemostat you can repeatedly crimp down and crush the fishhook barb flat. Carefully smooth all rough edges, and pull gently, backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (**Figure 7**).

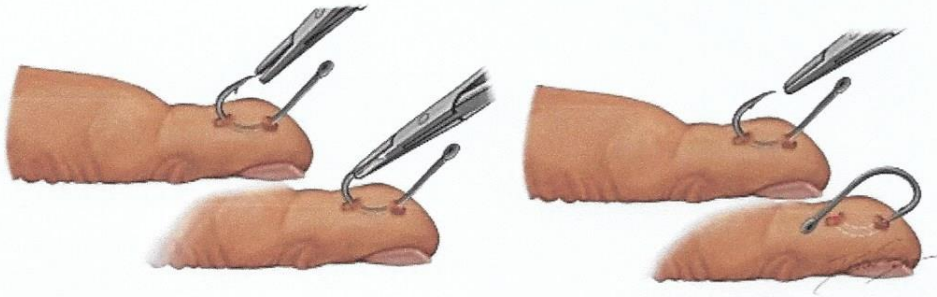


Figure 7. Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

Cut-It-Out Technique

The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.⁵ However, this should be a procedure of last resort in the ambulatory care setting, when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present. To perform, take a hemostat and pull up gently on the shaft of the hook, in a vertical direction. Next, take a scalpel (preferable a standard #11 blade type) and gently cut along the shaft of the distal end of the fishhook toward the proximal end with the barb. The hook can be then extracted and discarded. (See **Figure 8**) This technique consequently causes lots of tissue damage, and the resultant scar will likely have a jagged wound edge appearance.



Figure 8. Cut-it-out technique. Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.⁶ It involves two methods of removal: one for single-barbed fishhooks (**Figure 9**) and one for multiple-barbed fishhooks (**Figure 10**) where the non-embedded hooks are cut off prior to attempting removal.

Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin, alternatively a digital or regional block may be appropriate for various body site injuries.⁷ Using a hemostat or needle driver, with a strong grip and twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury.

The advance-and-cut technique is likely to be the most universally accepted in the urgent care, ambulatory care, and ED settings as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. Bear in mind that all wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients may have to be referred to the ED or hospital where a bolt cutter or surgical procedure may be required.

On first glance, it may appear that removing the shank barbs could obviate the need to drag them through the wound. However, it is difficult to stabilize the hook with a hemostat and try to remove the small multiple shank barbs (creating potentially multiple small flying objects as you try to snip them off). Cutting the tail end off, then pulling through, amounts to dragging the shank barbs intact through the tissue plane that has already been cut from the initial puncture

wound. This results in less risk of injury to the provider, less anxiety to the patient, and saves time of procedure.

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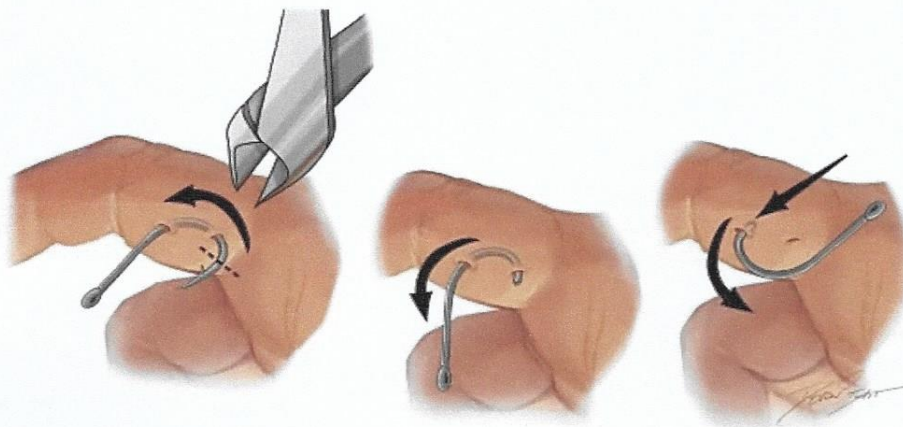


Figure 9. Advance-and-cut technique with a single barb fishhook. Advance the fishhook through the skin, creating an exit wound. Cut off the barb of the fishhook and back the remaining fishhook out the entry point. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

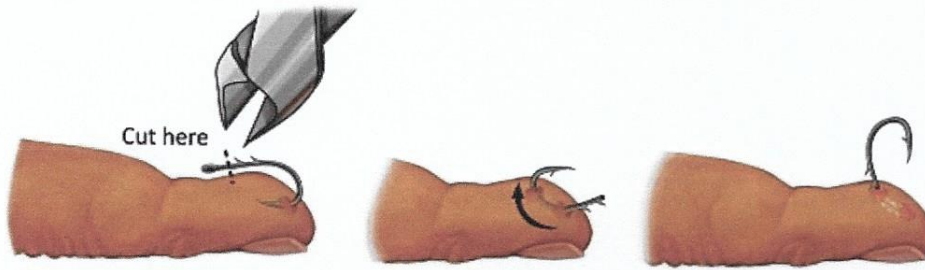


Figure 10. Advance-and-cut technique with a multiple barb fishhook. Advance the fishhook through the skin creating an exit wound. Cut the eye of the fishhook off and pull the remaining fishhook forward through the exit wound created by advancing the point through the skin. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

POSTREMOVAL WOUND CARE

After removal of the fishhook, the wound should be irrigated thoroughly with normal saline. All debris and foreign bodies should be removed. Finally, the wound should be covered with antibiotic ointment (mupirocin) and a sterile dressing. Wound care should include routine irrigation, cleansing (betadine), application of antibiotic ointment, and dressing change on a daily basis or every other day. Observations should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water two to three times a day until healing is observed.

Infections after fishhook removal are uncommon.¹ Therefore, routine use of antibiotics for uncomplicated superficial skin injuries is not indicated. For the rare cases in which there is reason for suspicion of infection and antibiotics are prescribed, consideration of coverage water-borne organisms is reasonable.

Patients should also be evaluated for tetanus prophylaxis. Tetanus-diphtheria or tetanus-diphtheria-pertussis (Td or Tdap) vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.

CONCLUSION

Fishhook injuries can occur at any time—during angling, commercial fishing, or simply cleaning out the garage. There is a need to establish a basic minimal procedural understanding by all healthcare providers involved in ambulatory care, urgent care, and emergency rooms for quick assessment and swift removal of fishhooks. This is an area where risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method. Always consider starting with the simpler removal techniques (ie, retrograde, needle cover) prior to the more robust methods mentioned in this article. Further, there is a need to establish a standard fishhook removal system that is as universal as the suture tray, containing a medically approved cutting device, along with hemostat, protective eye wear, and other supportive care supplies. Ensuring there is an established protocol, provider training, and a ready-to-use fishhook removal system on hand (ideally in close proximity

to a laceration repair kit) will increase the likelihood of both a positive clinical outcome and high patient satisfaction.

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Author affiliations: **Anthony G. Stanley, MD**, Criticare Clinics & Urgent Care, Miami, FL; Baptist Healthcare of South Florida; Stanley Medical Designs. Dr. Stanley holds patents for three medical devices, but has no relevant outside financial relationships with any commercial interests. **Jorge Murillo, MD, FIDSA, FACP**, Herbert Wertheim College of Medicine, Florida International University; Baptist Health System of South Florida. Dr. Murillo has no relevant financial relationships with any commercial interests.

Tagged on: Clinical Clinical Article Fishhook Foreign Body Removal

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**UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA**

MIAMI DIVISION

CASE NO. _____

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey
Limited Liability Company, d/b/a
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois
Corporation, d/b/a
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,
an Illinois Corporation, d/b/a
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

_____ /

EXHIBIT C
TO COMPLAINT FILED
FEBRUARY 28, 2023

Type of Work: Text

Registration Number / Date:
TXu002286333 / 2021-10-25

Application Title: Clinical Approach to Fishhook Removal.

Title: Clinical Approach to Fishhook Removal.

Description: Electronic file (eService)

Copyright Claimant:
Anthony Stanley.

Date of Creation: 2021

Authorship on Application:
Anthony George Stanley, 1957- ; Domicile: United States;
Citizenship: United States. Authorship: text, Revisions
to Article.

Previous Registration:
2021, TX0008995658.

Pre-existing Material:
text, Section titled "Post-Removal Wound Care".

Basis of Claim: text, Revisions and Edits.

Rights and Permissions:
Anthony Stanley, 7900 Harbor Island Drive, Unit #1514,
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Names: Stanley, Anthony George, 1957-
Stanley Anthony G.
Stanley, Anthony

=====

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Shira Perlmutter
United States Register of Copyrights and Director

Registration Number

TXu 2-339-980

Effective Date of Registration:

October 03, 2022

Registration Decision Date:

October 25, 2022



Title

Title of Work: Clinical Approach to Fishhook Removal

Completion/Publication

Year of Completion: 2021

Author

- Author:** Anthony G. Stanley
Author Created: text
Citizen of: United States
Domiciled in: United States
- Author:** Jorge Murillo
Author Created: text
Work made for hire: Yes
Citizen of: United States

Copyright Claimant

Copyright Claimant: Anthony G. Stanley
7900 Harbor Island Drive, Unit 1514, North Bay Village,, FL, 33141, United States
Transfer statement: By written agreement

Limitation of copyright claim

Material excluded from this claim: photograph(s), artwork

New material included in claim: text

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Certification

Name: Anastasia Latman
Date: October 03, 2022

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COLLEGE OF URGENT CARE MEDICINE.

Defendants.

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**EXHIBIT D
TO COMPLAINT FILED
FEBRUARY 28, 2023**



US009943971B2

(12) **United States Patent**
Stanley

(10) **Patent No.:** **US 9,943,971 B2**
(45) **Date of Patent:** **Apr. 17, 2018**

(54) **CUTTING TOOL**

(56)

References Cited

(71) Applicant: **Anthony G. Stanley**, North Bay Village, FL (US)

(72) Inventor: **Anthony G. Stanley**, North Bay Village, FL (US)

(*) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 185 days.

(21) Appl. No.: **14/825,306**

(22) Filed: **Aug. 13, 2015**

(65) **Prior Publication Data**

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24/11 R

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(60) Provisional application No. 62/044,555, filed on Sep. 2, 2014.

Stanley, Dr. Anthony G.; International Patent Application No. PCT/US15/44976; International Search Report; dated Nov. 23, 2015; 2 pages.

(Continued)

(51) **Int. Cl.**

B26B 11/00 (2006.01)
B26B 29/00 (2006.01)
B26B 27/00 (2006.01)
B26B 17/00 (2006.01)
A61B 17/50 (2006.01)
A61B 17/88 (2006.01)

Primary Examiner - Ghassem Alie

Assistant Examiner - Bharat C Patel

(74) *Attorney, Agent, or Firm* — Dority & Manning, PA

(57)

ABSTRACT

A cutting tool is described. The cutting tool can provide increased safety in residential, commercial, and/or medical applications. The cutting tool includes a container that can catch and/or hold material that is cut by use of the tool. This can prevent the cut material from flying indiscriminately away from the cutting tool at high velocity and can also prevent the cut material from falling to the floor/ground after cutting. The cutting tool can be sterilized for medical use, such as fish hook or jewelry removal.

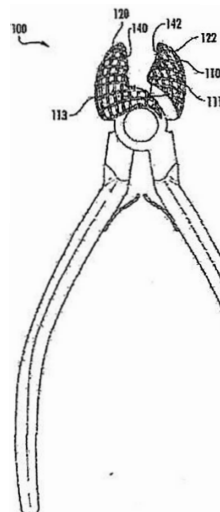
(52) **U.S. Cl.**

CPC **B26B 17/00** (2013.01); **A61B 17/50** (2013.01); **A61B 17/8863** (2013.01)

(58) **Field of Classification Search**

CPC **A61B 17/50**; **A61B 17/8863**; **B26B 7/00**
USPC 30/124
See application file for complete search history.

25 Claims, 16 Drawing Sheets





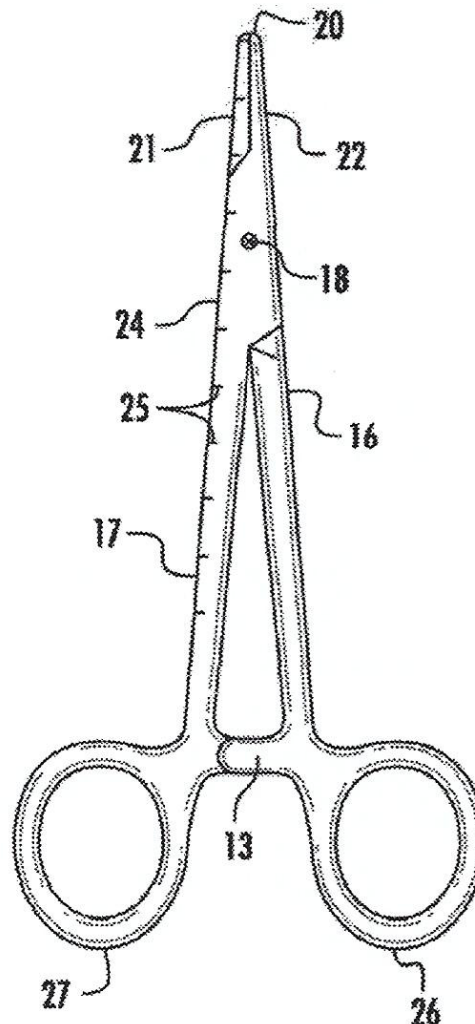
US 20160235498A1

(19) **United States**(12) **Patent Application Publication**
Stanley et al.(10) **Pub. No.: US 2016/0235498 A1**(43) **Pub. Date: Aug. 18, 2016**(54) **MEASURING DEVICES FOR MEDICAL TOOLS****Publication Classification**(71) Applicants: **Anthony G. Stanley**, North Bay Village, FL (US); **Donald L. Huzzie, Sr.**, Miami Gardens, FL (US)(51) **Int. Cl.**
A61B 90/00 (2006.01)
A61B 17/285 (2006.01)
A61B 17/28 (2006.01)(72) Inventors: **Anthony G. Stanley**, North Bay Village, FL (US); **Donald L. Huzzie, Sr.**, Miami Gardens, FL (US)(52) **U.S. Cl.**
CPC **A61B 90/06** (2016.02); **A61B 17/2812** (2013.01); **A61B 17/285** (2013.01); **A61B 17/282** (2013.01); **A61B 2090/061** (2016.02)(21) Appl. No.: **15/045,612**(22) Filed: **Feb. 17, 2016**(57) **ABSTRACT**

Measuring devices that can be incorporated with gripping tools are described. The measuring devices can be integral to a gripping tool or can be removably attachable to a gripping tool. The measuring devices can be incorporated in conjunction with a gripping tool for use in a medical application such as a clamp, a hemostat, a forceps, or the like. Devices can be utilized to determine a straight length and/or to determine the spread of the jaws a gripping tool associated with the device.

Related U.S. Application Data

(60) Provisional application No. 62/117,731, filed on Feb. 18, 2015.



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an Illinois Corporation, d/b/a
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

_____ /

EXHIBIT E
TO COMPLAINT FILED
FEBRUARY 28, 2023



Anthony Stanley MD <stanmeddesigns@gmail.com>

Successful 2022 Medical Device Establishment Registration

1 message

CDRH Registration and Listing <reglist@cdrh.fda.gov>
To: "stanmeddesigns@gmail.com" <stanmeddesigns@gmail.com>

Wed, Feb 23, 2022 at 9:41 PM

 Header

Dear Anthony Stanley:

This e-mail provides confirmation that the annual registration for the following medical device establishment has been successfully completed for 2022:

Registration Number:
Owner Operator Number: 10084436
STANLEY MEDICAL DESIGNS, INCORPORATED
[7900 Harbor Island Drive](#)
Suite 1514
North Bay Village, FL 33141
UNITED STATES

If you do not see a registration number assigned to the establishment and your establishment previously had one, please send an email to reglist@cdrh.fda.gov and include the registration number you believe is assigned to your establishment. We will review and determine if a duplicate registration has been created for your establishment.

Your registration is valid until December 31, 2022. Registration for 2023 will be conducted between October 1 and December 31, 2022.


Please note that registering your device facility and listing your devices does not, in any way, constitute FDA approval of your facility or your devices.

Should you have any questions, please send an e-mail to the CDRH Registration and Listing Helpdesk at reglist@cdrh.fda.gov.

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EXPERITY INC., an Illinois Corporation, d/b/a
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois
Corporation, d/b/a
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,
an Illinois Corporation, d/b/a
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

_____ /

EXHIBIT F
TO COMPLAINT FILED
FEBRUARY 28, 2023

Clinical Approach to Fishhook Removal

Submitted on Feb 16, 2021 - Manuscript ID: 1320812

[Start a discussion](#)

- [Anthony G. Stanley](#)

[Jun 4, 2021 - 11:11 am EDT](#)

[Article Credits](#)

[4](#)

[Hello Harris ; Dr. Murillo's name is spelled wrong can we make correction on some of the online d...](#)

- [Anthony G. Stanley](#)

[May 17, 2021 - 2:43 pm EDT](#)

[Receipt of your submission to JUCM](#)

[8](#)

[Ok great Harris. Looking forward to reading it along with family and friends. Yes please send a f...](#)

- [Anthony G. Stanley](#)

[Apr 29, 2021 - 11:41 am EDT](#)

[Article discussion and photos](#)

[4](#)

[Hello Harris: Just checking to see how the project is coming along. Let if you need my assistance...](#)

Discussion with *Journal of Urgent Care Medicine*

Article discussion and photos

- [Anthony G. Stanley](#)

[Apr 16, 2021 - 7:32 pm EDT](#)

[Hello Harris: I would like to contact you on Monday to discuss some aspects of the article and set up. I will try to contact you Monday 4/19/21 after 10:30am, if it is good timing for you.](#)

[Dr. Stanley](#)

- [Anthony G. Stanley](#)

[Apr 19, 2021 - 10:44 am EDT](#)

[hello](#)

[Attachments](#)

- [work copy an urgent care approach to fishhook removal](#)

- [Anthony G. Stanley](#)

[Help](#)

Apr 20, 2021 - 7:26 am EDT

Hello Harris:

I contacted all the photo copyright owners and cc you last evening. Attached is a composite contact list.

keep me posted.

Dr. Stanley

Attachments

- 2021 copy right granted list a autorecovered .docx
- Anthony G. Stanley

Apr 29, 2021 - 11:41 am EDT

Hello Harris:

Just checking to see how the project is coming along. Let if you need my assistance.

Take

Dr. Stanley

Post a response

bolditalicbulletsnumberslink

Add an attachment

Choose File

No file chosen

Add file

Allowed file types

You may upload the following types of files:

*.aac, *.avi, *.csv, *.doc, *.docx, *.flac, *.gif, *.html, *.jpeg, *.jpg, *.key, *.m4a, *.md, *.mov, *.mp3, *.mp4, *.mpeg, *.mpg, *.odt, *.pdf, *.png, *.pps, *.ppt, *.tex, *.tif, *.tiff, *.txt, *.xls, *.xml, *.zip

If you have a file that is unsupported please archive it within a ***.ZIP** file before uploading.

Post Message

X

Clinical Approach to Fishhook Removal

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[4](#)

[Hello Harris: Just checking to see how the project is coming along. Let if you need my assistance...](#)

Discussion with *Journal of Urgent Care Medicine*

Receipt of your submission to JUCM

- Harris Fleming

Feb 17, 2021 - 8:02 am EST

Dear Dr. Stanley,

Thank you for submitting your manuscript to *JUCM, The Journal of Urgent Care Medicine*. We appreciate your taking the time and the initiative to contribute to the growing body of urgent care literature.

Your article will be shared with a member of our clinical editorial team, after which I will update you on its status. You can expect to hear from me in 2 to 4 weeks. Typically, manuscripts that are accepted by our journal will to 6 months after submission, depending on seasonality, the peer and other factors.

Help

13

If you have any questions at any time, please email me at hfleming@jucm.com.

Thanks again.

Harris

Harris Fleming
Executive Editor
JUCM, The Journal of Urgent Care Medicine

- Anthony G. Stanley
Mar 2, 2021 - 8:54 am EST
Hello Harris: Just checking in. This is my first journal article. Let me know if you need any information from me, medical illustrations, photos etc...

Have a great day!
Dr. Stanley
- Harris Fleming
Apr 30, 2021 - 12:01 pm EDT
Dr. Stanley,
Right now your manuscript is being read by a couple members of our peer review panel. It's the final step before preparing the article for publication. I will let you know whether or not they have any queries. I've asked them to get back to me no later than today.

Thank you for checking in.

Harris
- Anthony G. Stanley
May 5, 2021 - 6:31 pm EDT
Hello Harris: I reviewed the article . I made a few rearrangements of photos to make everything flow a little better. I was able to cut the page count from 13 to 12. Content not changed but truncated to conserve space.
I included my x ray of the fish hooked finger which has been a inspiration point for me writing this article (PATIENT EVALUATION), hope its no problem. I like your edits of the article and satisfied with the results.

Dr. Stanley

Attachments

- [jucm 0621 clinical fishhook post peer review 2.docx](#)
- [jucm article disclosure form ags.pdf](#)
- Anthony G. Stanley
May 10, 2021 - 7:57 am EDT
Good Morning Harris;
Here are two photos of me to choose from and Disclosure from Dr. Murrilo.
Have a great week.
Dr. Stanley

Attachments

- [dr.stanley.jpg](#)
- [dr. stanley.jpg](#)
- [jucm disclosure form3 28 21jm.pdf](#)
- Anthony G. Stanley
May 17, 2021 - 1:31 pm EDT
Hello Harris:

Just checking if you know if the article is slated for June or July issue?
Also please send a copy of the final layout plans (copy and photos) of the article.

Thanks

Dr. Stanley

- Harris Fleming
May 17, 2021 - 2:39 pm EDT
Hi, Dr. Stanley.

Your article will be featured on the cover of the June issue, which goes to press this week. I will be happy to send you a few copies after we've received the excess back from the printer, which will probably be in the second week of June. Unfortunately, we're unable to share the layout in advance of publication. It will be available online starting on June 1.

Harris

- Anthony G. Stanley
May 17, 2021 - 2:43 pm EDT

Ok great Harris. Looking forward to reading it along with family and friends. Yes please send a few copies when you can!

Have a great week

Post a response

bold**italic****bullets****numbers****link**

Add an attachment

Choose File

No file chosen

Add file

Allowed file types

You may upload the following types of files:

*.aac, *.avi, *.csv, *.doc, *.docx, *.flac, *.gif, *.html, *.jpeg, *.jpg, *.key, *.m4a, *.md, *.mov, *.mp3, *.mp4, *.mpeg, *.mpg, *.odt, *.pdf, *.png, *.pps, *.ppt, *.tex, *.tif, *.tiff, *.txt, *.xls, *.xml, *.zip

If you have a file that is unsupported please archive it within a ***.ZIP** file before uploading.

Post Message

X

Clinical Approach to Fishhook Removal

Submitted on Feb 16, 2021 - Manuscript ID: 1320812

[Start a discussion](#)

- [Anthony G. Stanley](#)

[Jun 4, 2021 - 11:11 am EDT](#)

[Article Credits](#)

[4](#)

[Hello Harris ; Dr. Murillo's name is spelled wrong can we make correction on some of the online d...](#)

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[Receipt of your submission to JUCM](#)

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[Ok great Harris. Looking forward to reading it along with family and friends. Yes please send a f...](#)

- [Anthony G. Stanley](#)

[Apr 29, 2021 - 11:41 am EDT](#)

[Article discussion and photos](#)

[4](#)

[Hello Harris: Just checking to see how the project is coming along. Let if you need my assistance...](#)

Discussion with *Journal of Urgent Care Medicine*

Article Credits

- Anthony G. Stanley

[Jun 1, 2021 - 12:46 pm EDT](#)

Hello Fleming:

I wanted see if my photo can be added to the On-line version and add me to the Authors Bios Section.

Thanks

Dr. Stanley

Attachments

◦ [dr. stanley.jpg](#)

◦ [post review.docx](#)

- Harris Fleming

[Help](#)

Jun 1, 2021 - 11:40 pm EDT

Dr. Stanley,

Yes, your photo and your information will be added when the standalone PDF version of your article is uploaded to the website. There is a lag between publication of the issue and its articles and their addition to the archives, which coincides with updating the author bios.

Thank you for asking (and, again, for your excellent contribution).

Harris

- Anthony G. Stanley

Jun 2, 2021 - 10:53 am EDT

Hi Harris:

Thanks for the info. Oh by the way , I wanted to know if in the future , can you send me any statistical data in regards to the article readership .

How many clicks and that sort of info if it is available?

Just want to gauge where it is on the popularity list over time!

Thanks again.

- Anthony G. Stanley

Jun 4, 2021 - 11:11 am EDT

Hello Harris ; Dr. Murillo's name is spelled wrong can we make correction on some of the online documents?

If possible;

Jorge Murillo

Dr. Stanley

Post a response

[bolditalicbulletsnumberslink](#)

Add an attachment

Choose File

No file chosen

Add file

Allowed file types

You may upload the following types of files:

*.aac, *.avi, *.csv, *.doc, *.docx, *.flac, *.gif, *.html, *.jpeg, *.jpg, *.key, *.m4a, *.md, *.mov, *.mp3, *.mp4, *.mpeg, *.mpg, *.odt, *.pdf, *.png, *.pps, *.ppt, *.tex, *.tif, *.tiff, *.txt, *.xls, *.xml, *.zip

If you have a file that is unsupported please archive it within a ***.ZIP** file before uploading.

Post Message

X



Anthony Stanley MD <stanmeddesigns@gmail.com>

Sample Photo release form

6 messages

Anthony Stanley MD <stanmeddesigns@gmail.com>

Thu, Feb 6, 2020 at 8:52 PM

To: editor@jucm.com

Hello My name is Anthony Stanley, MD:

I am currently working on a **clinical review article** to JUCM with in the near future. Currently I am obtaining permission for a photo and graphics, I would like to use from the internet. Do you have a sample **photo release form**, that I can reference and covers the scope of your concerns at the Journal of Urgent Care Medicine.

Thank you
Anthony G. Stanley, MD

Harris Fleming <hfleming@jucm.com>

Thu, Feb 6, 2020 at 9:57 PM

To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Dr. Stanley,

Thank you for your email, and for your interest in submitting an article to *JUCM*. We appreciate your initiative very much.

We do not have a standard form for requesting permission to use images that have appeared in other publications or online. Rather, each copyright holder maintains their own permissions process. When you're ready to submit your manuscript, simply included images that would suit your needs. We will seek permission to use them once your article is accepted, or find suitable alternatives through services we work with regularly.

May I ask the topic your clinical review article will address, so we can ensure we don't already have one on a similar subject in the mix?

Harris

Harris Fleming

Executive Editor

JUCM, The Journal of Urgent Care Medicine

hfleming@jucm.com

[Quoted text hidden]

Anthony Stanley MD <stanmeddesigns@gmail.com>

Mon, Feb 10, 2020 at 11:06 AM

To: Harris Fleming <hfleming@jucm.com>

Mr. Harris: Thanks for your response. The title of my paper is **Clinical Approach to Fishhook Removal**. It is shaping to be a very comprehensive summary.

I have a few general question regarding the submission and acceptance JUCM policy. This is my first article and just want to get a better understanding of the process. If the article is accepted what are the advantages of being published in the JUCM: circulation wise, etc...? Am I allowed to submit the article to another medical journal or are there any limitations I should be aware of?

Thanks
Dr. Stanley

[Quoted text hidden]

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: Harris Fleming <hfleming@jucm.com>

Mon, Feb 15, 2021 at 6:45 PM

Hello Mr. Fleming:

Its Dr. Stanley. We talked last year in February (2020); about an article I was writing. Hope all is well. I have been busy with work/ pandemic, gathering permission for photos, and restructuring my article. The article is going to be a **comprehensive review of fish hook removal**, with all the latest concepts put together in one place. I have lots of diagrams to demonstrate the various techniques. Lots of photos provided by a collaboration with **fishermen, wildlife societies and a medical art illustrator**. I have worked many years perfecting various procedures and want to present an article that Doctors, ARNP, and PA's, can have on their desktop or i-pad for quick reference.

I will be sending the article your way on Wednesday via the SCHOLASTICA portal.

Once received please send me an email so I will know it arrived, and will go from there.

Anthony G. Stanley, MD

(305) 439-7274

[Quoted text hidden]

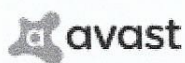
Harris Fleming <hfleming@jucm.com>
To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Tue, Feb 16, 2021 at 9:21 AM

Thank you, Dr. Stanley. I will be on the lookout for and confirm receipt of your submission. When it does arrive, it will be assigned to one of our clinical editors for review. I will update you on its status after we've had a chance to discuss it, which should be within 2 weeks after receipt.

Harris

[Quoted text hidden]



This email has been checked for viruses by Avast antivirus software.
www.avast.com

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: Harris Fleming <hfleming@jucm.com>

Tue, Feb 16, 2021 at 9:23 AM

Sounds good, thank you!

[Quoted text hidden]



Anthony Stanley MD <stanmeddesigns@gmail.com>

New Clinical Review Article

1 message

Anthony Stanley MD <stanmeddesigns@gmail.com>

Mon, Feb 15, 2021 at 7:01 PM

To: editor@jucm.com

Hello Dr. Russell:

My name is Anthony G. Stanley, MD. from sunny Miami Beach, Florida. I am currently working on a **clinical review article** to submit to the Journal of Urgent Care Medicine. The article is going to be a comprehensive review of **fish hook removal**, with all the latest concepts put together in one place. As more people start to get back to fishing, subsequently more injuries will be presenting to the health care facilities. What I wanted to create, is a procedural review and guideline article. I have lots of updated diagrams to demonstrate the various techniques. Lots of photos provided by a collaboration with **fishermen, wildlife societies and a medical art illustrator**. I have worked many years perfecting various procedures and want to present an article that Doctors, ARNP, and PA's, can have on their desktop or i-pad for quick reference.

I will be sending the article your way on Wednesday via the SCHOLASTICA portal.

Once received please send me an email so I will know it arrived.

Anthony G. Stanley, MD

(305) 439-7274



Anthony Stanley MD <stanmeddesigns@gmail.com>

New Clinical Review Article

3 messages

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: leeresnick@sbcglobal.net

Mon, Feb 15, 2021 at 6:57 PM

Hello Mr. Fleming:

Its Dr. Stanley. We talked last year in February (2020); about an article I was writing. Hope all is well. I have been busy with work/ pandemic, gathering permission for photos, and restructuring my article. The article is going to be a **comprehensive review of fish hook removal**, with all the latest concepts put together in one place. I have lots of diagrams to demonstrate the various techniques. Lots of photos provided by a collaboration with **fishermen, wildlife societies and a medical art illustrator**. I have worked many years perfecting various procedures and want to present an article that Doctors, ARNP, and PA's, can have on their desktop or i-pad for quick reference.

I will be sending the article your way on Wednesday via the SCHOLASTICA portal.

Once received please send me an email so I will know it arrived, and will go from there.

Anthony G. Stanley, MD
(305) 439-7274

Lee Resnick <leeresnick@sbcglobal.net>

Mon, Feb 15, 2021 at 10:43 PM

To: Anthony Stanley MD <stanmeddesigns@gmail.com>, Harris Fleming <hfleming@jucm.com>

Dr Stanley,

I am forwarding your email to Harris Fleming for review and response. I didn't see him copied on your email below. I am no longer editor of JUCM, but Harris can get you connected

Lee A. Resnick, MD

[Quoted text hidden]

Anthony Stanley MD <stanmeddesigns@gmail.com>

Tue, Feb 16, 2021 at 6:50 AM

To: Lee Resnick <leeresnick@sbcglobal.net>
Cc: Harris Fleming <hfleming@jucm.com>

Great, thanks!

[Quoted text hidden]



Anthony Stanley MD <stanmeddesigns@gmail.com>

Update on you JUCM submission

9 messages

Harris Fleming <hfleming@jucm.com>

Mon, Mar 8, 2021 at 10:54 PM

To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Dr. Stanley,

Thank you for your patience as your submission has worked its way through our editorial team. In short, I'm happy to let you know that your article has been accepted pending your response to a few suggested edits from our clinical editors. I will be sending you an annotated version of the article explaining what those are within the next few days.

Harris

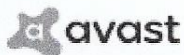
Harris Fleming

Executive Editor

JUCM, The Journal of Urgent Care Medicine

Phone: 201-248-2834

Email: hfleming@jucm.com



This email has been checked for viruses by Avast antivirus software.
www.avast.com

Anthony Stanley MD <stanmeddesigns@gmail.com>

Tue, Mar 9, 2021 at 12:26 PM

To: Harris Fleming <hfleming@jucm.com>

Hello Harris; That is great news! Looking forward to reviewing the edits.

Thanks

Dr. Stanley

[Quoted text hidden]

Anthony Stanley MD <stanmeddesigns@gmail.com>

Thu, Mar 25, 2021 at 8:03 AM

To: Harris Fleming <hfleming@jucm.com>

Good morning Harris:

Any updates from the editorial team?

Thanks

Dr. Stanley

[Quoted text hidden]

Harris Fleming <hfleming@jucm.com>
To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Thu, Mar 25, 2021 at 11:14 AM

Hi, Dr. Stanley.

Thanks again for your patience. We had a couple of disruptions in the review chain, but I do have an annotated document with recommended edits to your article. It's attached here.

You don't need to go to the trouble of accepting the edits that are tracked; I just wanted you to be aware of them. If you disagree with anything, please note that in a comment for our consideration. One question you'll see several times is where the images were sourced from. They're a great help and it would be nice to include as many as possible, assuming we can get permission from the copyright holders. If any of them are your own, please note that so we can add the appropriate attribution.

I'm also attaching a disclosure form for our CME accreditor. (As you may know, readers can get CME credit for answering questions on select articles in each issue.) Please complete it and return it to me, and ask Dr. Murriilo to do the same.

Our plan is to publish this as the lead clinical article in the June or July issue due to the timeliness of the topic.

Thank you so much for offering us the opportunity to share this with our readers.

Harris

From: Anthony Stanley MD <stanmeddesigns@gmail.com>
Sent: Thursday, March 25, 2021 8:03 AM
To: Harris Fleming <hfleming@jucm.com>
Subject: Re: Update on you JUCM submission

Good morning Harris:

Any updates from the editorial team?

Thanks

Dr. Stanley

On Tue, Mar 9, 2021 at 12:26 PM Anthony Stanley MD <stanmeddesigns@gmail.com> wrote:

Hello Harris; That is great news! Looking forward to reviewing the edits.

Thanks

Dr. Stanley

On Mon, Mar 8, 2021 at 10:54 PM Harris Fleming <hfleming@jucm.com> wrote:

Dr. Stanley,

Thank you for your patience as your submission has worked its way through our editorial team. In short, I'm happy to let you know that your article has been accepted pending your response to a few suggested edits from our clinical editors. I will be sending you an annotated version of the article explaining what those are within the next few days.

Harris

Harris Fleming

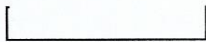
Executive Editor

JUCM, The Journal of Urgent Care Medicine

Phone: 201-248-2834

Email: hfleming@jucm.com

This email has been checked for viruses by Avast antivirus software.
www.avast.com



2 attachments



Clinical - Fishhook Removal JUCM notes.docx
1575K



JUCM Disclosure Form.pdf
224K

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: Harris Fleming <hfleming@jucm.com>

Tue, Mar 30, 2021 at 8:08 AM

Good morning Harris: Attached is my disclosure form. Will send Dr. Murillo's letter shortly. **I am also composing a list of photo contributors with contact information.**

[Quoted text hidden]

 **JUCM Disclosure Form AGS.pdf**
507K

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: Harris Fleming <hfleming@jucm.com>

Fri, Apr 16, 2021 at 4:34 PM

Hello Harris: is it possible to talk on the phone, This coming Monday around 10:30 am. I have put together a list of photo contributors and contact information. I have a few questions to ask before sending on Monday. Let me know what time works for you on Monday 4/18/2021

Thanks

Dr. Stanley

[Quoted text hidden]

Harris Fleming <hfleming@jucm.com>
To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Fri, Apr 16, 2021 at 5:23 PM

Dr. Stanley,

Yes, we can speak on Monday. Would that be 10:30 am Eastern time? Whichever, please feel free to call me at 201-248-2834. Or, let me if you'd prefer that I give you a call.

Thank you!

[Quoted text hidden]

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: Harris Fleming <hfleming@jucm.com>

Mon, Apr 19, 2021 at 8:08 AM

Good morning Harris:

I will be totally free at that time. But it may be better for you to call , your agenda maybe not as flexible as mine. I am preparing for a discussion on a few aspects of the article and compiling the source list.
My phone (305) 439-7274

Talk to you soon

Dr. Stanley

[Quoted text hidden]

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: Harris Fleming <hfleming@jucm.com>

Mon, Apr 19, 2021 at 10:24 AM

Hello Harris; I am sending you an updated work copy of the current edits to go over in today's discussion
Dr. Stanley .

[Quoted text hidden]

 **Work Copy_An Urgent Care Approach to Fishhook Removal.docx**
1642K



Anthony Stanley MD <stanmeddesigns@gmail.com>

Peer review of your JUCM submission

1 message

Harris Fleming <hfleming@jucm.com>
To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Tue, May 4, 2021 at 6:19 PM

Greetings, Dr. Stanley.

Your article came through the peer review process with flying colors (an average of 4 out of 5 stars). There was just one substantive query, noted as a comment in the attached. Could you please take a look at that and let me know what you think?

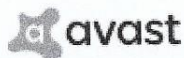
Also, I wanted to thank you for facilitating permission for us to use the photos and illustrations. We may not be able to use every one, but this gives our art director a great selection.

I do have one final request: Could you and Dr. Murrilo please complete and return the attached disclosure form? Readers will be able to get CME credit for reading your article, and will need to supply these to our CME accreditor. If you could each include a photo (a standard headshot would be fine) of yourself, that would also be helpful.

Thanks very much for all your help.

Harris

Harris Fleming
Executive Editor
JUCM, The Journal of Urgent Care Medicine
Phone: 201-248-2834
Email: hfleming@jucm.com



This email has been checked for viruses by Avast antivirus software.
www.avast.com

2 attachments



JUCM 0621 Clinical - Fishhook Post Peer Review.docx
1416K



JUCM Disclosure Form.pdf
224K



Anthony Stanley MD <stanmeddesigns@gmail.com>

Article Concerns

7 messages

Anthony Stanley MD <stanmeddesigns@gmail.com>

Fri, Jun 11, 2021 at 7:16 AM

To: swilliams@jucm.com

Bcc: Lee Resnick <leeresnick@sbcglobal.net>, Harris Fleming <hfleming@jucm.com>, editor@jucm.com

Dear Mr. Williams (**Journal of Urgent Care Medicine / Braveheart Group, LLC**):

This is Dr. Stanley. It's in regards to the article **An Urgent Care Approach to Fishhook Removal**. I read the article online and have **some broad concerns** and **questions**. Can you call me on Monday June 14, 2021 9am to 10 am.

Thank you

Anthony G. Stanley,MD

305-439-7274

Harris Fleming <hfleming@jucm.com>

Fri, Jun 11, 2021 at 7:29 AM

To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Cc: swilliams@jucm.com

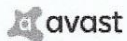
Good morning, Dr. Stanley.

I'm sorry to hear you have concerns about your article. It would be most helpful, however, if you detail them in an email so we can look into them.

Thank you.

Harris

[Quoted text hidden]



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www.avast.com

Anthony Stanley MD <stanmeddesigns@gmail.com>

Fri, Jun 11, 2021 at 8:07 AM

To: Harris Fleming <hfleming@jucm.com>

Hello Harris:

We will discuss the details during our telephone call conversation on Monday.

Dr. Stanley

[Quoted text hidden]

Harris Fleming <hfleming@jucm.com>

Mon, Jun 14, 2021 at 8:16 AM

To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Dr. Stanley,

As I explained in my previous email, the best and promptest course to understanding and looking into your concerns will be through a detailed email. We are engaged in preparing our July issue for publication all week and I'm afraid I will not have any availability for a conference call.

I appreciate your understanding and hope you will let me know your concerns in writing so we can look into them once the July issue is off to the printer.

Harris

From: Anthony Stanley MD <stanmeddesigns@gmail.com>

Sent: Friday, June 11, 2021 8:08 AM

To: Harris Fleming <hfleming@jucm.com>
Subject: Re: Article Concerns

Hello Harris:

We will discuss the details during our telephone call conversation on Monday.

Dr. Stanley

On Fri, Jun 11, 2021 at 7:29 AM Harris Fleming <hfleming@jucm.com> wrote:

Good morning, Dr. Stanley.

I'm sorry to hear you have concerns about your article. It would be most helpful, however, if you detail them in an email so we can look into them.

Thank you.

Harris

From: Anthony Stanley MD <stanmeddesigns@gmail.com>
Sent: Friday, June 11, 2021 7:16 AM
To: swilliams@jucm.com
Subject: Article Concerns

Dear Mr. Williams (Journal of Urgent Care Medicine / Braveheart Group, LLC):

This is Dr. Stanley. It's in regards to the article **An Urgent Care Approach to Fishhook Removal**. I read the article online and have **some broad concerns** and **questions**. Can you call me on Monday June 14, 2021 9am to 10 am.

Thank you

Anthony G. Stanley, MD

305-439-7274

This email has been checked for viruses by Avast antivirus software.
www.avast.com

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: Harris Fleming <hfleming@jucm.com>
Cc: swilliams@jucm.com, Lee Resnick <leeresnick@sbcglobal.net>, editor@jucm.com

Mon, Jun 14, 2021 at 1:37 PM

Mr. Harris Fleming (Journal of Urgent Care Medicine / Braveheart Group, LLC):

This serves as an acknowledgement of your email. However, it is regrettable that you are unavailable to participate in a telephone discussion.

This is my **second notification** to you, regarding the multiple errors published in the article, **An Urgent Care Approach to Fishhook Removal (on-line and print)**. As you recall, as **the expert**, I was denied access to proof the final article prior to the JUCM's printing. For this reason, it is imperative that we formulate a corrective plan of action. These errors if allowed to remain as published **pose severe risk and negative outcomes** in the delivery of patient care. I do speak from experience as a medical professional.

I am anticipating a telephone conversation, at your earliest convenience in order to avoid the possibility of litigation to resolve this matter.

Again, **my availability by telephone** will be **Wednesday, June 16th, 2021. 9am to 10am**

Anticipating your earliest response.

Sincerely

Anthony Stanley, MD
(305) 439-7274
[Quoted text hidden]

Harris Fleming <hfleming@jucm.com>
To: Anthony Stanley MD <stanmeddesigns@gmail.com>
Cc: swilliams@jucm.com

Mon, Jun 14, 2021 at 3:43 PM

Dr. Stanley,

We are aware that you have concerns, as noted in my previous responses to your emails. Stu Williams and I have cleared our schedules for a conference call this Wednesday at 9:30 am, as you requested. You probably already received an invitation via email.

It would still be helpful to know the nature of your concerns in advance of our call so we can make good use of our time. Please follow up with an email detailing them so we can get straight to it on Wednesday.

Also, FYI, Dr. Resnick is no longer engaged in the operations of the journal. Please refrain from including him on the distribution of future emails.

[Quoted text hidden]

Anthony Stanley MD <stanmeddesigns@gmail.com>
To: Harris Fleming <hfleming@jucm.com>

Good morning Mr. Harris:

After your e-mail response **early yesterday**, I called an attorney and they advised me to stop communication and just let them handle the matter. I realized your time is valuable, I spent the 1 hour shifts, sleeping poorly and concentrating poorly, trying to find all the mistakes the JUCM printed and how to correct them. No need for you or Mr. Williams or Journal of Urgent Care M. The damage to my reputation has been done and in the records of history forever. Now it is a matter of how to protect the public from misinformation and confusion in that article "A". We will let members of the legal system (do the JUCM homework and) read the original paper and final print to figure out why things went astray. **Be aware that** there is no need for you to call me tomorrow June 16th.

Have a good day!
Dr. Stanley

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**UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA**

MIAMI DIVISION

CASE NO. _____

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey
Limited Liability Company, d/b/a
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a
EXPERITY HEALTH, and


URGENT CARE ASSOCIATION, INC., an Illinois
Corporation, d/b/a
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,
an Illinois Corporation, d/b/a
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

_____ /

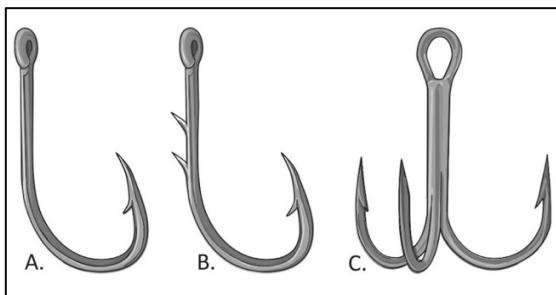
EXHIBIT G
TO COMPLAINT FILED
FEBRUARY 28, 2023

<p>Approved Article:</p> <p>INTRODUCTION</p> <p>Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and urgent care facilities, especially among those who participate in the sport of fishing with a rod and line known (or "angling"). There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands.¹ What has been seldomly recognized is the occurrence of injury to bystanders, as well as to accompanying pets and wildlife. These types of injury are referred to as <i>collateral damage</i>..</p>  <p>Photo courtesy of Thundermist Lure Company.</p>	<p>Online Article:</p> <p>INTRODUCTION</p> <p>Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and urgent care facilities, especially among those who participate in the sport of fishing with a rod and line known (or "angling"). There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands. 1 What has been seldomly recognized is the occurrence of injury to bystanders, as well as to accompanying pets and wildlife. These types of injury are referred to as collateral damage.</p> <p>[PHOTOGRAPH REMOVED]</p>
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<p>Approved Article:</p> <p>ANATOMY OF THE FISHHOOK—AND WHY IT MATTERS</p> <p>The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the</p>	<p>Online Article:</p> <p>ANATOMY OF THE FISHHOOK-AND WHY IT MATTERS</p> <p>The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the</p>
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discretion of the provider. Tetanus status should be accessed and Td or Tdap administered if needed with age appropriateness as per established guidelines.

There are three classic types of fishhooks: single-barbed, multiple-barbed, and treble (Figure 1). There are common features among them, however (Figure 2). In each, the "eye" connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The "point" is the sharp end that penetrates the fish's mouth or skin. The gape or gap describes the distance between the shank and the point. When examining the patient, it is important to note



whether the fishhook is single-barbed or multiple-barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.

Figure 1. Classic types of fishhooks: A, single barbed fishhook; B, multiple barbed fishhook; C, treble fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

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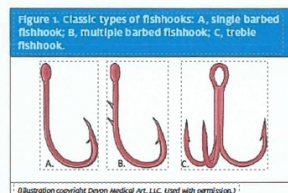
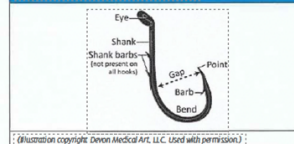


Figure 2. Anatomy of the fishhook.



[ARTWORK DISTORTED AND CONFUSINGLY MISPLACED]

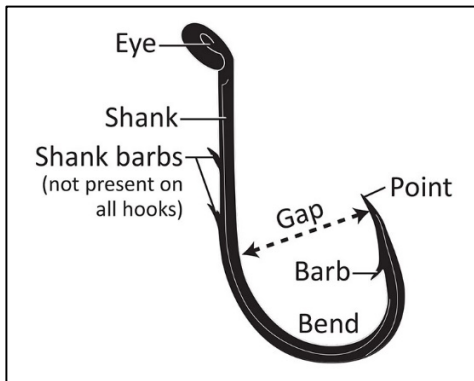


Figure 2. Anatomy of the fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

Approved Article:

PATIENT EVALUATION

After obtaining a history of the injury, vital signs, a quick survey of the wound and surrounding structures should be made. Inspect distal and proximal to the injury site. Assess for deep injury involving penetration to tendons, nerves, and bone. Radiographs are seldom needed, but may aid in determining the type of fishhook and the depth of penetration.


Most fishhook injuries are penetrating soft-tissue injuries of the hand, face, head or upper extremity but can involve other body parts. Injuries usually do not involve deeper tissue structures because of the linear forces applied along the fishing line to the curved shape fishhook that brings the point parallel to the skin and keep it from deep penetration.³ Any eye injury penetrating wounds should be stabilized and transported to the nearest ED. Bear in mind that the cutting capacity of wire cutters is limited. In cases involving larger fishhooks, the patient may have to be referred to the ED where larger surgical cutting devices are available (ie, bolt cutter or an extensive surgical procedure may be required).

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 <p>Photo courtesy of A G Stanley, MD.</p>	<p>[PHOTOGRAPH REMOVED]</p>
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<p>Approved Article:</p> <p>PRINCIPLES OF REMOVAL</p> <p>The six most common techniques for the removal of fishhooks are:</p> <ol style="list-style-type: none"> 1. Retrograde 2. String-yank 3. Needle 4. Barb crush 5. Cut-it-Out 6. Advance-and-cut <p>The method selected is based on the judgment of the provider, the anatomic location of the injury, and the type and anatomy of fishhook. Before you get started make sure that you have of a fishhook removal system. At minimal, this will require:</p> <ol style="list-style-type: none"> 1. Wire cutter 2. Hemostat or needle driver 3. Gloves 4. Wound cleanser 5. Protective eyewear (goggles or face shield) 6. Local anesthetic 	<p>Online Article:</p> <p>PRINCIPLES OF REMOVAL</p> <p>The six most common techniques for the removal of fishhooks are:</p> <ol style="list-style-type: none"> 1. Retrograde 2. String-yank 3. Needle cover 4. Barb crush 5. Cut-it-out 6. Advance-and-cut <p>The method selected is based on the judgment of the provider, the anatomic location of the injury, and the type and anatomy of fishhook. Before you get started make sure that you have of a fishhook removal system. At minimal, this will require:</p> <ol style="list-style-type: none"> 1. Wire cutter 2. Hemostat or needle driver 3. Gloves 4. Wound cleanser 5. Protective eyewear (goggles or face shield) 6. Local anesthetic
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The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank methods}. Often times multiple techniques must be attempted before the fishhook is successfully removed.

In the clinical setting, local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, hexachlorophene solution before attempting removal of the fishhook. Patients who contact the urgent care center before arrival can be advised to wash the wound with soap and water. Local anesthesia typically lidocaine 1% (Xylocaine) without epinephrine. A nerve block or regional block may also be required depending on the injury site. Hooks with more than one point like the treble fishhook should have the free barbs taped or cut to avoid additional embedded puncture wounds during the removal procedure. All items attached to the hook (eg, fish line, bait, and the body of the lure itself) should be removed. The provider and bystanders should take care not to be struck by the hook during removal. Anyone assisting with the procedure should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the string-yank method and advance-and-cut method.

Trauma Gallery



Photo courtesy of Steve Weeks.

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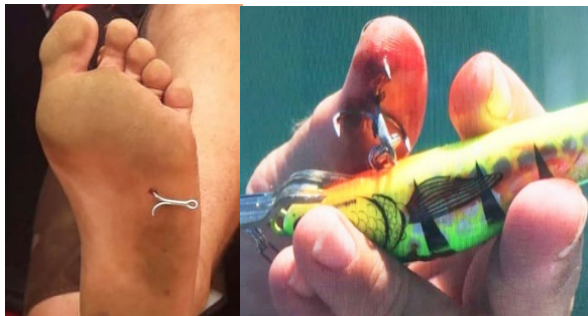
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Photo courtesy of Chris Barry.



Photo courtesy of *Fishing World Magazine*.



Photo(s) courtesy of Karen Rudkin-Moody and Ryan Moody.

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Approved Article:

Retrograde Technique

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the hook. This maneuver pushes the hook deeper into the tissue bed and dislodges the barb, from the resting tissue site. The hook can then be backed out of the skin along the path of entry (Figure 3). If there is any resistance or snagging sensation of the barb during the procedure, consider an alternate method.

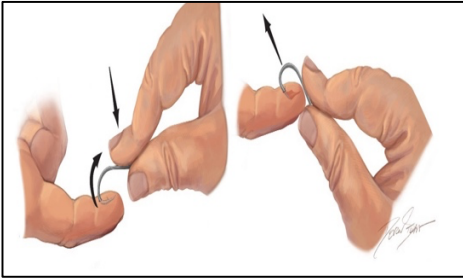


Figure 3.

Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



Photo courtesy of Ty Southerland.

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Figure 3. Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

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Approved Article:

String-Yank Technique

The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires

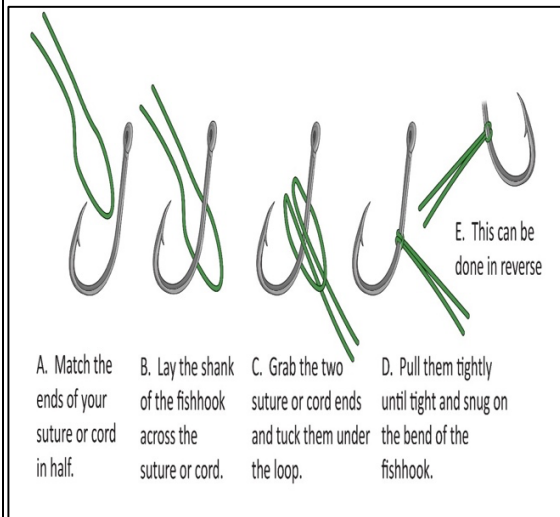
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<p>anesthesia. This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).</p> <p>The tradition of counting <i>1,2,3, go</i> (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.</p> <p>Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position, use a simple knot such as a lark's head knot (Figure 4). Wrap the free ends around the index finger of the free hand.</p>	<p>This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).</p> <p>The tradition of counting <i>1,2,3, go</i> (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.</p> <p>Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position, use a simple knot such as a lark's head knot (Figure 4). Wrap the free ends around the index finger of the free hand.</p> <p>A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft. The involved skin area should be well stabilized against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (Figure 5A). Fishhooks extracted with this technique will come out with significant velocity, so the provider and bystanders should remain out of the line of flight and wear protective eye wear</p>
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Figure 4. Applying a lark's head knot to a fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

Figure 5. String-yank method. A: Tie a string using a lark's head knot around the midpoint of the bend in the fishhook. B: Depress the shank of the fishhook against the skin. Press firmly and quickly yank/pull on the string while maintaining continued pressure to the shank of the hook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

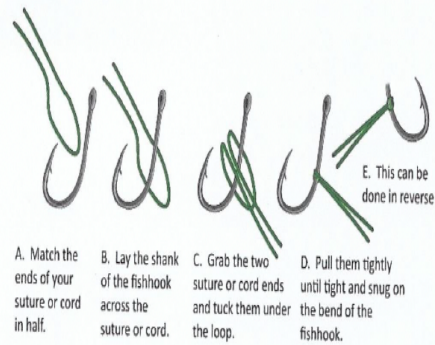
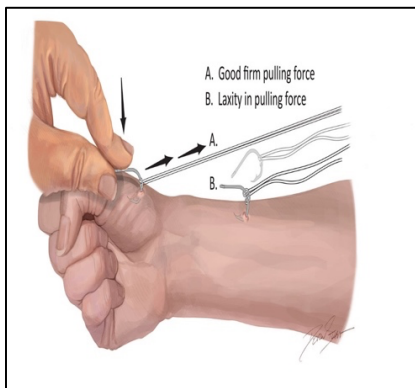


Figure 4. Applying a lark's head knot to a fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

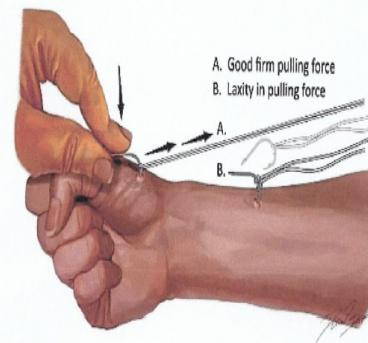


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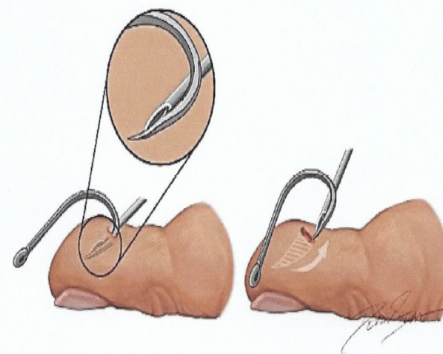
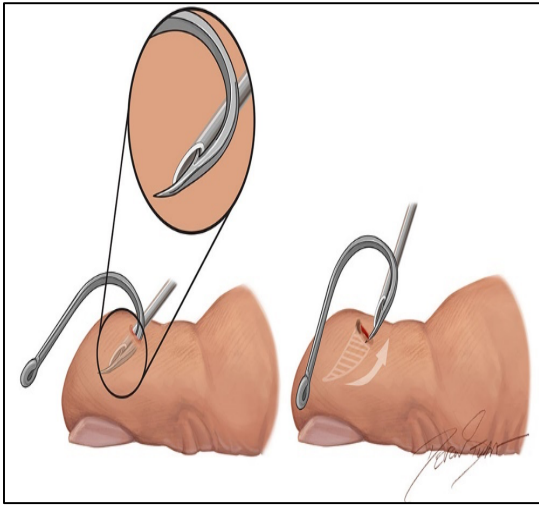


Figure 6. Needle cover method. Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps the barb. The fishhook and needle are then pulled back and removed as a single unit. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

[FIGURE 6 ARTWORK PLACED IN INCORRECT SECTION (Needle Cover Technique)]

	[ARTWORK CHANGED]	DESCRIPTION	POSITION
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<p>Approved Article:</p> <p>Needle Cover Technique</p> <p>The needle cover technique requires great dexterity on the part of the provider (and a little luck). It works well for the removal of large hooks with a single barb, and when the point of the fishhook is superficially embedded in the skin (surface).</p> <p>After standard wound prep and local anesthesia, a 16-18-gauge needle is advanced along the wound entrance of the fishhook (Figure 6). The direction of insertion should be parallel to the shank. The bevel should point toward the inside of the curve of the fishhook, enabling the needle opening to cover over (capping off) the barb. It is important to have the bevel pointed in the correct direction as shown so that the leading edge of the needle matches the angle of the fishhook barb. Advance the fishhook to disengage the barb, then pull and wiggle it so that the point enters the lumen of the needle. Once covered, back out the fishhook (similar to the retrograde technique), taking care to move the needle along the entry point of the fishhook.</p> <p>Figure 6. Needle cover method. Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps, the barb. The fishhook and needle are then pulled back and removed as a single unit. (Illustration copyright Devon Medical Art, LLC. Used with permission.)</p>	<p>Online Article: [PAGE MISSING]</p>
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A modification of this technique involves sliding a #11 scalpel blade along the wound to the point of the fishhook. The fishhook may then be backed out thru the track of the incision line.

Approved Article:

Barb Crush Technique

The barb crush technique is considered another modification of the Retrograde Technique, but with a higher success rate.

Often, there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fishhook (shank). Using a pair of pliers or sturdy hemostat you can repeatedly crimp down and crush the fishhook barb flat. Carefully smooth all rough edges, and pull gently, backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (Figure 7).

Figure 7. Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes. (Illustration copyright

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Devon Medical Art, LLC. Used with permission.)

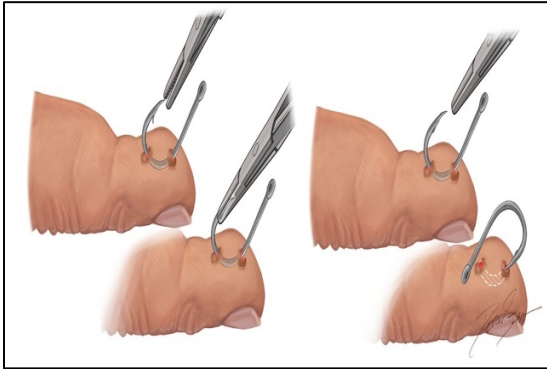


Figure 7. Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

[ARTWORK DESCRIPTION POSITION CHANGED]

Approved Article:

Cut-It-Out Technique

The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.⁵ However, this should be a procedure of last resort in the ambulatory care setting, when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present.

To perform, take a hemostat and pull up gently on the shaft of the hook, in a vertical direction. Next, take a scalpel (preferable a standard #11 blade type) and gently cut along the shaft of the distal end of the fishhook toward the proximal end with the barb. The hook can be then extracted and discarded. (See Figure 8) This technique consequently causes lots of tissue damage, and the

Online Article:

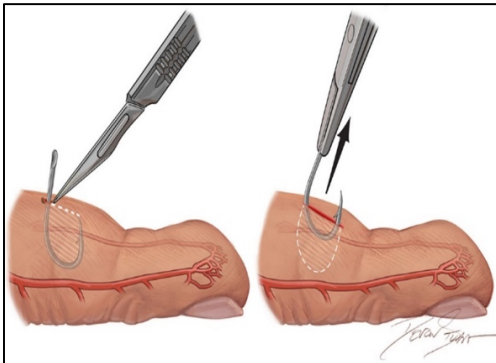
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resultant scar will likely have a jagged wound edge appearance.

Figure 8. Cut-it-out technique. Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



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Figure 8. Cut-it-out technique. Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

[ARTWORK DESCRIPTION POSITION CHANGED]

Approved Article:

Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.⁶ It involves two methods of removal: one for single-barded fishhooks (Figure 9) and one for multiple-barbed fishhooks (Figure 10) where the non-embedded hooks are cut off prior to attempting removal.

Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin, alternatively a digital or regional block may be appropriate for various body site injuries.⁷ Using a hemostat or needle driver, with a strong grip and

Online Article:

Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.⁶ It involves two methods of removal: one for single-barded fishhooks (Figure 9) and one for multiple-barbed fishhooks (Figure 10) where the non-embedded hooks are cut off prior to attempting removal.

Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin, alternatively a digital or regional block may be appropriate for various body site injuries.⁷ Using a hemostat or needle driver, with a strong grip and

twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury.

The advance-and-cut technique is likely to be the most universally accepted in the urgent care, ambulatory care, and ED settings as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. Bear in mind that all wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients may have to be referred to the ED or hospital where a bolt cutter or surgical procedure may be required.

Figure 9. Advance-and-cut technique with a single barb fishhook. Advance the fishhook through the skin, creating an exit wound. Cut off the barb of the fishhook and back the remaining fishhook out the entry point. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury.

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[NEWLY ADDED SECTION]

On first glance, it may appear that removing the shank barbs could obviate the need to drag them through the wound. However, it is difficult to stabilize the hook with a hemostat and try to remove the small multiple shank barbs (creating potentially multiple small flying objects as you try to snip them off). Cutting the tail end off, then pulling through, amounts to dragging the shank barbs intact through the tissue plane that has already been

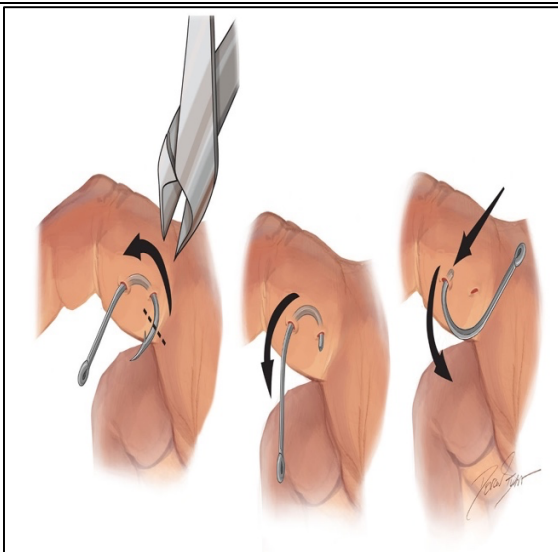
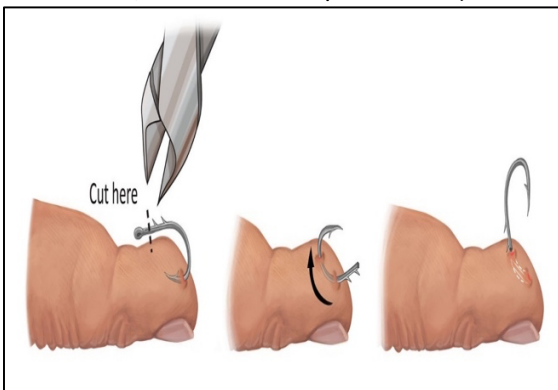


Figure 10. Advance-and-cut technique with a multiple barb fishhook. Advance the fishhook through the skin creating an exit wound. Cut the eye of the fishhook off and pull the remaining fishhook forward through the exit wound created by advancing the point through the skin. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



cut from the initial puncture wound. This results in less risk of injury to the provider, less anxiety to the patient, and saves time of procedure.

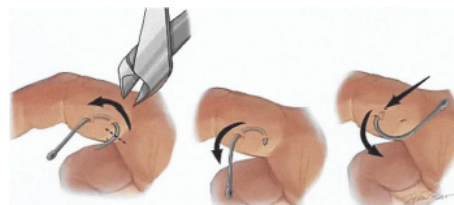


Figure 9. Advance-and-cut technique with a single barb fishhook. Advance the fishhook through the skin, creating an exit wound. Cut off the barb of the fishhook and back the remaining fishhook out the entry point. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

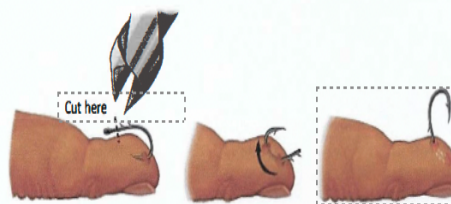


Figure 10. Advance-and-cut technique with a multiple barb fishhook. Advance the fishhook through the skin creating an exit wound. Cut the eye of the fishhook off and pull the remaining fishhook forward through the exit wound created by advancing the point through the skin. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

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Approved Article:

INTRODUCTION

Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and urgent care facilities, especially among those who participate in the sport of fishing with a rod and line known (or "angling"). There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands.¹ What has been seldomly recognized is the occurrence of injury to bystanders, as well as to accompanying pets and wildlife. These types of injury are referred to as *collateral damage*.



Photo courtesy of Thundermist Lure Company.

Printed Article:

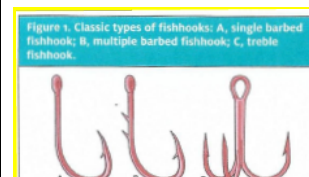
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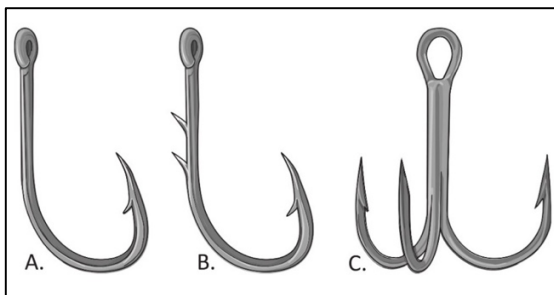
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"Tetanus-diphtheria or tetanus-diphtheria-pertussis vaccine should be administered if there is a history of less than three doses or unknown doses of

	<p><i>tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required. "</i></p> <p>[RANDOM QUOTE PLACEMENT]</p>
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<p>Approved Article:</p> <p>ANATOMY OF THE FISHHOOK—AND WHY IT MATTERS</p> <p>The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the discretion of the provider. Tetanus status should be assessed and Td or Tdap administered if needed with age appropriateness as per established guidelines.</p>	<p>Printed Article:</p> <p>Anatomy of the Fishhook – and Why It Matters</p> <p>Anatomy of the Fishhook-and Why It Matters The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the discretion of the provider. Tetanus status should be ascertained. [SENTENCE CHANGED]</p> <p>There are three classic types of fishhooks: single-barbed, multiple-barbed, and treble (Figure 1). There are common features among them, however (Figure 2). In each, the "eye" connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The "point" is the sharp end that penetrates the fish's mouth or skin. The gape or gap describes the distance between the shank and the point. When examining the patient, it is important to note whether the fishhook is single-barbed or multiple-barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook</p>
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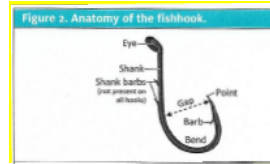
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whether the fishhook is single-barbed or multiple-barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.

Figure 1. Classic types of fishhooks: A, single barbed fishhook; B, multiple barbed fishhook; C, treble fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

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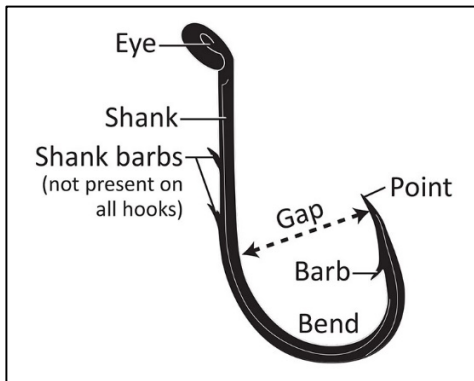


Figure 2. Anatomy of the fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

Approved Article:

PATIENT EVALUATION

After obtaining a history of the injury, vital signs, a quick survey of the wound and surrounding structures should be made. Inspect distal and proximal to the injury site. Assess for deep injury involving penetration to tendons, nerves, and bone. Radiographs are seldom needed, but may aid in determining the type of fishhook and the depth of penetration.

Most fishhook injuries are penetrating soft-tissue injuries of the hand, face, head or upper extremity but can involve other body parts. Injuries usually do not involve deeper tissue structures because of the linear forces applied along the fishing line to the curved shape fishhook that brings the point parallel to the skin and keep it from deep penetration.³ Any eye injury penetrating wounds should be stabilized and transported to the nearest ED. Bear in mind that the cutting capacity of wire cutters is limited. In cases involving larger fishhooks, the patient may have to be referred to the ED where larger surgical cutting devices are available (ie, bolt cutter or an extensive surgical procedure may be required).

Printed Article:

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Photo courtesy of A G Stanley, MD.

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Approved Article:

PRINCIPLES OF REMOVAL

The six most common techniques for the removal of fishhooks are:

1. Retrograde
2. String-yank
3. Needle
4. Barb crush
5. Cut-it-Out
6. Advance-and-cut

The method selected is based on the judgment of the provider, the anatomic location of the injury, and the type and anatomy of fishhook. Before you get started make sure that you have of a fishhook removal system. At minimal, this will require:

1. Wire cutter
2. Hemostat or needle driver
3. Gloves
4. Wound cleanser
5. Protective eyewear (goggles or face shield)
6. Local anesthetic

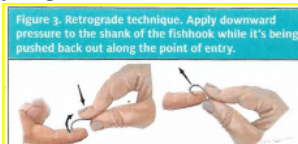
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The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank methods}. Often times multiple techniques must be attempted before the fishhook is successfully removed.

In the clinical setting, local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, hexachlorophene solution before attempting removal of the fishhook. Patients who contact the urgent care center before arrival can be advised to wash the wound with soap and water. Local anesthesia typically lidocaine 1% (Xylocaine) without epinephrine. A nerve block or regional block may also be required depending on the injury site. Hooks with more than one point like the treble fishhook should have the free barbs taped or cut to avoid additional embedded puncture wounds during the removal procedure. All items attached to the hook (eg, fish line, bait, and the body of the lure itself) should be removed. The provider and bystanders should take care not to be struck by the hook during removal. Anyone assisting with the procedure should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the string-yank method and advance-and-cut method.

Trauma Gallery



Photo courtesy of Steve Wecks.

1. Wire cutter
2. Hemostat or needle driver
3. Gloves
4. Wound cleanser
5. Protective eyewear (goggles or face shield)
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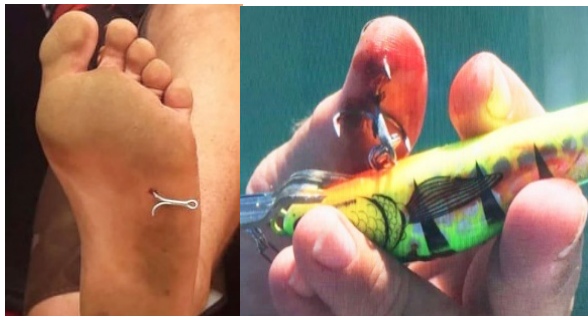
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Photo courtesy of Chris Barry.



Photo courtesy of *Fishing World Magazine*.



Photo(s) courtesy of Karen Rudkin-Moody and Ryan Moody.

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Approved Article:

Retrograde Technique

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the hook. This maneuver pushes the hook deeper into the tissue bed and dislodges the barb, from the resting tissue site. The hook can then be backed out of the skin along the path of entry (Figure 3). If there is any resistance or snagging sensation of the barb during the procedure, consider an alternate method.

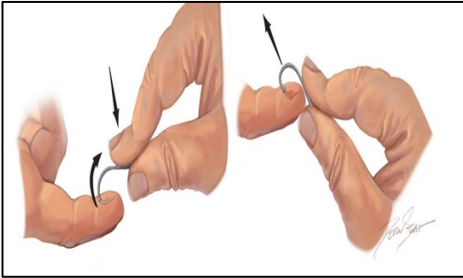


Figure 3.

Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

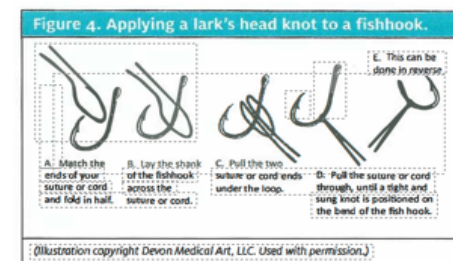


Photo courtesy of Ty Southerland.

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[FIGURE 3 ARTWORK REMOVED]

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[FIGURE 4 ARTWORK PLACED IN INCORRECT LOCATION]

Approved Article:

String-Yank Technique

The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires

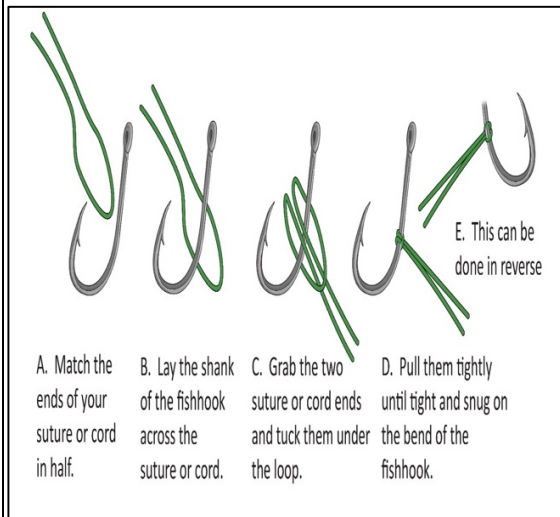
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<p>anesthesia. This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).</p> <p>The tradition of counting <i>1,2,3, go</i> (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.</p> <p>Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position, use a simple knot such as a lark's head knot (Figure 4). Wrap the free ends around the index finger of the free hand.</p>	<p>This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).</p> <p>The tradition of counting <i>1,2,3, go</i> (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.</p> <p>Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position, use a simple knot such as a lark's head knot (Figure 4). Wrap the free ends around the index finger of the free hand.</p> <p>A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft. The involved skin area should be well stabilized against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (Figure 5A). Fishhooks extracted with this technique will come out with significant velocity, so the provider and bystanders should remain out of the line of flight and wear protective eye wear</p>
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Figure 5. String-yank method. A: Tie a string using a lark's head knot around the midpoint of the bend in the fishhook. B: Depress the shank of the fishhook against the skin. Press firmly and quickly yank/pull on the string while maintaining continued pressure to the shank of the hook.

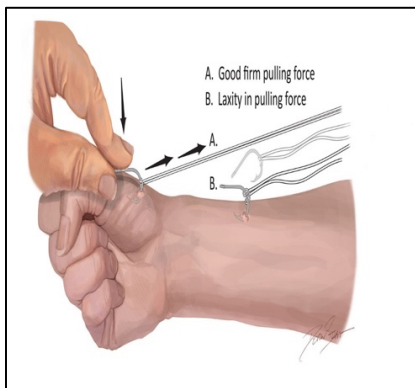


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[FIGURE 4 AND 5 ARTWORK REMOVED FROM SECTION]

Figure 4. Applying a lark's head knot to a fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

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Approved Article:

Needle Cover Technique

The needle cover technique requires great dexterity on the part of the provider (and a little luck). It works well for the removal of large hooks with a single barb, and when the point of the fishhook is superficially embedded in the skin (surface).

After standard wound prep and local anesthesia, a 16-18-gauge needle is advanced along the wound entrance of the fishhook (Figure 6). The direction of insertion should be parallel to the shank. The bevel should point toward the inside of the curve of the fishhook, enabling the needle opening to cover over

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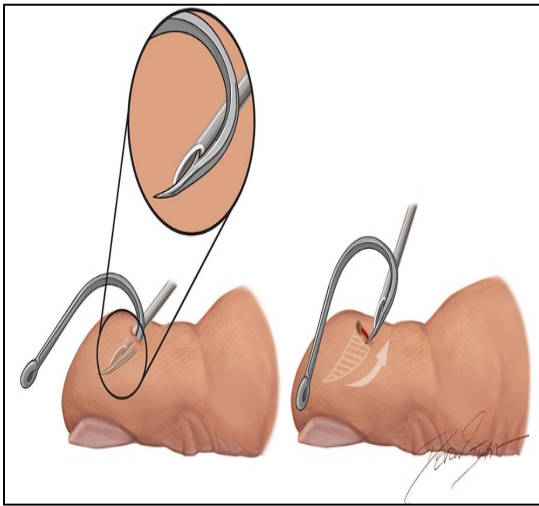
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(capping off) the barb. It is important to have the bevel pointed in the correct direction as shown so that the leading edge of the needle matches the angle of the fishhook barb. Advance the fishhook to disengage the barb, then pull and wiggle it so that the point enters the lumen of the needle. Once covered, back out the fishhook (similar to the retrograde technique), taking care to move the needle along the entry point of the fishhook.

Figure 6. Needle cover method. Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps, the barb. The fishhook and needle are then pulled back and removed as a single unit. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



A modification of this technique involves sliding a #11 scalpel blade along the wound to the point of the fishhook. The fishhook may then be backed out thru the track of the incision line.

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[FIGURE 6 ARTWORK REMOVED FROM SECTION]

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Approved Article:

Barb Crush Technique

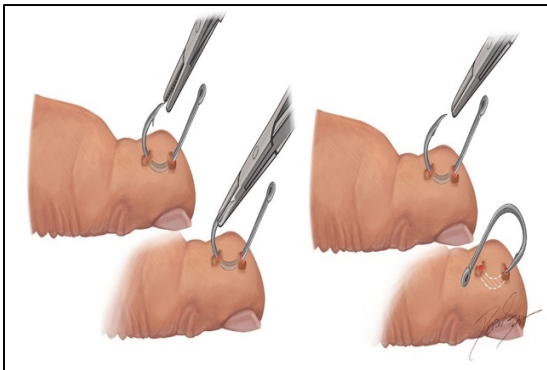
Printed Article:

Barb Crush Technique

The barb crush technique is considered another modification of the Retrograde Technique, but with a higher success rate.

Often, there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fishhook (shank). Using a pair of pliers or sturdy hemostat you can repeatedly crimp down and crush the fishhook barb flat. Carefully smooth all rough edges, and pull gently, backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (Figure 7).

Figure 7. Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



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[FIGURE 7 ARTWORK REMOVED FROM SECTION]

Approved Article:

Cut-It-Out Technique

The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.⁵ However, this should be a procedure of last resort in the

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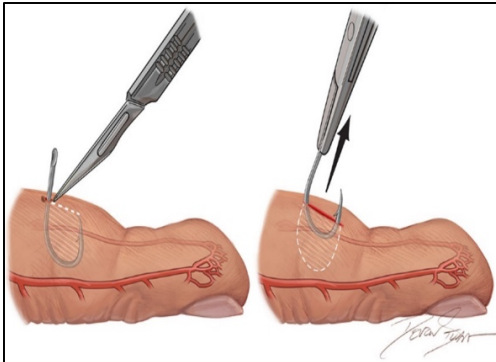
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The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.⁵ However,

ambulatory care setting, when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present.

To perform, take a hemostat and pull up gently on the shaft of the hook, in a vertical direction. Next, take a scalpel (preferable a standard #11 blade type) and gently cut along the shaft of the distal end of the fishhook toward the proximal end with the barb. The hook can be then extracted and discarded. (See Figure 8) This technique consequently causes lots of tissue damage, and the resultant scar will likely have a jagged wound edge appearance.

Figure 8. Cut-it-out technique. Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



this should be a procedure of last resort in the ambulatory care setting,

Figure 7. Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes.



[ARTWORK DISTORTED/PLACED IN INCORRECT LOCATION]

when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present.

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[FIGURE 8 ARTWORK REMOVED FROM SECTION]

Approved Article:

Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is

Printed Article:

Advance-and-Cut Technique

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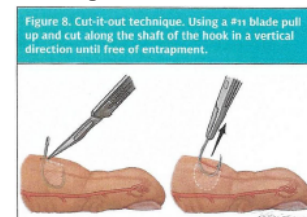
caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.⁶ It involves two methods of removal: one for single-barded fishhooks (Figure 9) and one for multiple-barbed fishhooks (Figure 10) where the non-embedded hooks are cut off prior to attempting removal.

Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin, alternatively a digital or regional block may be appropriate for various body site injuries.⁷ Using a hemostat or needle driver, with a strong grip and twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury.

The advance-and-cut technique is likely to be the most universally accepted in the urgent care, ambulatory care, and ED settings as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. Bear in mind that all wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients

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Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin; [SEMI-COLON ADDED] alternatively, [COMMA ADDED] a digital or regional block may be appropriate for various body site injuries.⁷ Using a hemostat or needle driver, with a strong grip and twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting



[ARTWORK DISTORTED/PLACED IN INCORRECT LOCATION]

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may have to be referred to the ED or hospital where a bolt cutter or surgical procedure may be required.

Figure 9. Advance-and-cut technique with a single barb fishhook. Advance the fishhook through the skin, creating an exit wound. Cut off the barb of the fishhook and back the remaining fishhook out the entry point. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

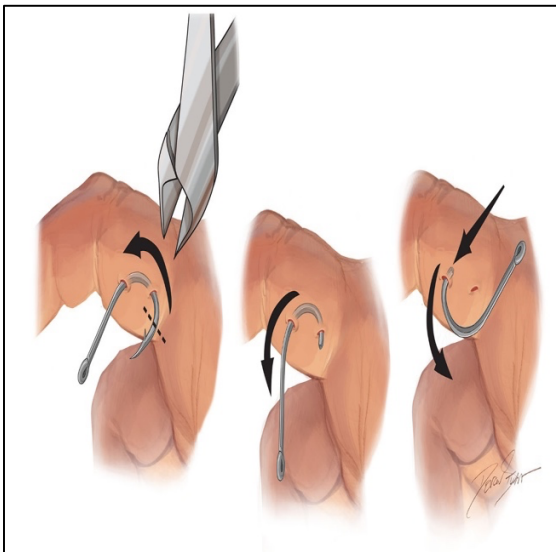


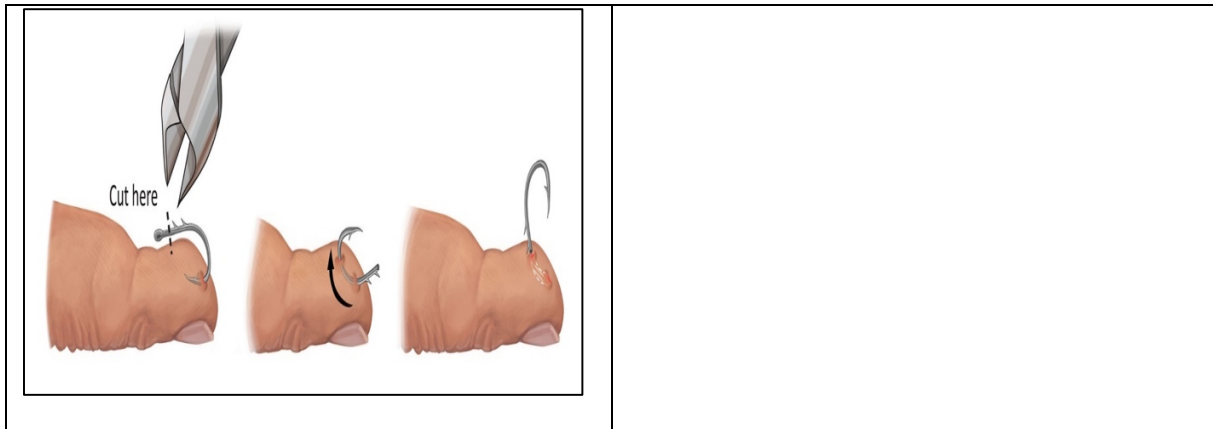
Figure 10. Advance-and-cut technique with a multiple barb fishhook. Advance the fishhook through the skin creating an exit wound. Cut the eye of the fishhook off and pull the remaining fishhook forward through the exit wound created by advancing the point through the skin. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

care, ambulatory care, and ED settings as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. Bear in mind that all wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients may have to be referred to the ED or hospital where a bolt cutter or surgical procedure may be required.

[FIGURE 9 AND 10 ARTWORK REMOVED FROM SECTION]

[NEWLY ADDED SECTION]

On first glance, it may appear that removing the shank barbs could obviate the need to drag them through the wound. However, it is difficult to stabilize the hook with a hemostat and try to remove the small multiple shank barbs (creating potentially multiple small flying objects as you try to snip them off). Cutting the tail end off, then pulling through, amounts to dragging the shank barbs intact through the tissue plane that has already been cut from the initial puncture wound. This results in less risk of injury to the provider, less anxiety to the patient, and saves time of procedure.



Approved Article:

POSTREMOVAL WOUND CARE

After removal of the fishhook, the wound should be irrigated thoroughly with normal saline. All debris and foreign bodies should be removed. Finally, the wound should be covered with antibiotic ointment (mupirocin) and a sterile dressing. Wound care should include routine irrigation, cleansing (betadine), application of antibiotic ointment, and dressing change on a daily basis or every other day. Observations should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water two to three times a day until healing is observed.

Infections after fishhook removal are uncommon.¹ Therefore, routine use of antibiotics for uncomplicated superficial skin injuries is not indicated. For the rare cases in which there is reason for suspicion of infection and antibiotics are prescribed, consideration of coverage water-borne organisms is reasonable.

Patients should also be evaluated for tetanus prophylaxis. Tetanus-diphtheria or tetanus-

Printed Article:

Postremoval Wound Care

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[ARTWORK DISTORTED/PLACED IN INCORRECT LOCATION]

"Risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method."

[RANDOM QUOTE PLACEMENT]

<p>diphtheria-pertussis (Td or Tdap) vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.</p>	<p>irrigation, cleansing (betadine), application of antibiotic ointment, and dressing change on a daily basis or every other day. Observations should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water two to three times a day until healing is observed.</p> <p>Infections after fishhook removal are uncommon. ¹ Therefore, routine use of antibiotics for uncomplicated superficial skin injuries is not indicated. For the rare cases in which there is reason for suspicion of infection and antibiotics are prescribed, consideration of coverage water-borne organisms is reasonable.</p> <p>Patients should also be evaluated for tetanus prophylaxis. Tetanus-diphtheria or tetanus-diphtheria-pertussis (Td or Tdap) vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.</p>
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**UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA**

MIAMI DIVISION

CASE NO. _____

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey
Limited Liability Company, d/b/a
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois
Corporation, d/b/a
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,
an Illinois Corporation, d/b/a
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

_____ /

EXHIBIT H
TO COMPLAINT FILED
FEBRUARY 28, 2023



Anthony Stanley MD <stanmeddesigns@gmail.com>

Article Retraction Request

3 messages

Anthony Stanley MD <stanmeddesigns@gmail.com>

Wed, Jun 23, 2021 at 9:07 AM

To: editor@jucm.com

Cc: swilliams@jucm.com, Harris Fleming <hfleming@jucm.com>

6/23/2021

Dear **Journal of Urgent Care Medicine / Braveheart Group, LLC/ Experity Health:**

You recently printed an unauthorized article on June 1, 2021 in the JUCM, entitled **An Urgent Care Approach to Fishhook Removal** under my name which is not my writings. It is superimposed with editorial comments placed by the JUCM and medical advice injected, not authorized by me. I came to your company with integrity, honesty and fairness. However, I was not treated with the same. I want to know why did you do such a thing? The peer reviews your website advertise, worked as a peer take over and operated under inadequate supervision of the editing and rewriting process. The paper is filled with grammatical errors and omitted steps in medical procedural concepts due to unskillful cutting and pasting. I worked and researched the article contents for **7 years** and it's now in ruins as well as my medical reputation. An opportunity to proof the final article was intentionally taken away from me. Why did you do such a thing? Do you take over from **every author, every month** and **deny all authors final proofing** or did you just, **decided to choose** me? Were your actions, **Racially Motivated** or what was your reason? Was your hastiness due to the old acronym Publish or Perish (ideological thinking). **How can you sleep at night knowing what you have done?**

Key sections of my work were wrongfully discarded. There are sections in the paper that your non doctoral staff contributed, giving **medical advice and misinformation** which may have damaging effects if readers act on **wrongful medical advice in performance of patient care**. Read what your agents wrote into the article and compare it to the original submission in the **Scholastica portal**. I am asking that the article be retracted and my original writings be printed unchanged. I was asked to write your organization and **"simply ask, the Journal of urgent Care Medicine to retract the article and remove it from any form of technological circulation"**. I hold all parties mentioned (and copied in this email) accountable and ask for an internal audit of your activity and participation in this event. I look forward to your response. I am very, very disappointed in the JUCM and what has taken place. I hope we can work together to rectify the issues, prevent harm to the readers acting on misinformation and come to a reasonable solution. Your website talks about integrity, honesty and fairness but as you can see by the treatment shown to me, those claims are not true. All of the **doctors on your JUCM staff have a medical license, and** all took a **"Hippocratic Oath"**, I am sure they realized the importance of retracting the article in all forms and setting the record straight, to protect the public. **At the advice of an attorney, I am sending you this letter to "simply ask"**.

Sincerely

swilliams@jucm.com <swilliams@jucm.com>

To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Wed, Jun 23, 2021 at 11:27 AM

Dr. Stanley,

I'm sorry to hear that you weren't happy with our publishing your article.

On May 4th, you were sent a version of the manuscript of your article that included edits necessitated after our internal medical review comments, and external peer reviewer comments. You may have forgotten that on May 5th, you sent an email to Executive Editor Harris Fleming acknowledging the receipt of the revised manuscript, and replied "I like your edits and am satisfied with your results". Upon receipt of your approval, this exact version of the manuscript was sent to our designer for layout.

I don't understand what the problem is, now that the article has been published. You approved the content, in writing. As our medical staff and peer reviewers have agreed, it is a valuable contribution to the medical literature on an important topic in urgent care medicine.

I see no reason to retract this article.

Best wishes,

Stuart



Stuart Williams

Publisher

p: 201-529-4004

[Quoted text hidden]

Anthony Stanley MD <stanmeddesigns@gmail.com>
Draft To: swilliams@jucm.com

Wed, Jun 23, 2021 at 12:38 PM

Hello Mr. Williams: This is the first time you have formally entered the picture. Welcome! Please try to keep the facts correct. The version (work copy #2 that was corrected by me and) I sent to Mr. Harris on May 5th is not the version you printed June 1, 2021 online. There is an old Jamacian saying "out of evil, cometh good". I am sure we both will have a clearer understanding with time. The problem still stands as stated in the previous emails. **By your statements today**, It appears you printed an unauthorized version. Recheck your emails time and date. It seems that all emails go to you or Mr. Harris, do you guys own the JUCM?

Dr. Stanley

[Quoted text hidden]

**UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA**

MIAMI DIVISION

CASE NO. _____

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey
Limited Liability Company, d/b/a
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois
Corporation, d/b/a
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,
an Illinois Corporation, d/b/a
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

_____ /

EXHIBIT I
TO COMPLAINT FILED
FEBRUARY 28, 2023

Petition for Article Retraction

To: Braveheart Group LLC d/b/a "The Journal of Urgent Care Medicine"
185 State Route 17, Suite 4
Mahwah, NJ 07430

Dear Journal of Urgent Care Medicine (JUCM):

We the undersigned are licensed medical providers (MD, DO, ARNP, PA-C, RN) working in the Urgent Care setting. We the undersigned are familiar with caring for fishhook injured patients, with Dr. Stanley and his work in fishhook removal education over the past several years.

Upon reading the article in your JUCM magazine on-line and printed dated June 1, 2021, entitled "An Urgent Care Approach to Fishhook Removal" we have been unfortunately surprised by the medical misinformation multiple grammatical errors that the JUCM publication presented to the medical community. We've had the opportunity of reading Dr. Stanley's original article entitled "Clinical Approach to Fishhook Removal" and the JUCM's printed version entitle "An Urgent Care Approach of Fishhook Removal" for comparative purposes and have reached the following conclusions.

The current JUMC article gives the reader, a viewpoint that fishhook injured people go to the Urgent Care centers, located in recreation areas, and that they go to the Urgent Cares, during the vacation season. These three unverified clinical assumptions are not factual medical information. There is no National data on the incidence of fishhook injury, no information on seasonal incidence, no information on geographical or regional location centers of concentrated injury. If you read the printed article's citation # 2, you will find no information to support the claims stated in the article regarding the incidence and occurrence of Fishhook injury.

The original article as written by Dr. Stanley was geared to alert the reader of the mindfulness of needing to track valuable incidence data and bring about a renewed approach to fishhook injury and treatment strategies. In reading the printed JUCM version in comparison to the original version it is evident that Dr. Stanley's information was cut and pasted out of the article, producing multiple typographical errors, and leaving poorly explained, disjointed medical concepts (e.g., "Fish hook Removal System") and, leaving the reader with only technical information of fishhook removal.

The original article furthermore has several pictures of actual patients who have provided their consent to use the images in question to bring home several points of injury awareness and diversity in skill needed to consider removal of this type of foreign body. All photos in the original article and related information were unexplainably deleted in the final version. It is, however, noticeable that JUCM has placed their own photos in the published article.


We have analyzed both versions of the article in question and believe that the readers were denied the full scope of Dr. Stanley's insight into this field of medicine, and ultimately denied valuable clinical information intended for the provider who will be faced with the difficult challenge of removing fishhooks from patients. Further, the article has

excessive brightly colorized diagrams that are of unacceptable poor visibility, all instructional diagrams listed in the article are located at the top of the pages and do not flow with the written text easily as originally intended. This arrangement requires the readers to constantly look up and look down and could potentially lead to them becoming confused. Providers, who may need to reference this article quickly in current format, (which is full of grammatical errors, disjointed through concepts and difficult to follow text) could become confused.

In conclusion, this current article "An Urgent Care Approach to Fishhook Removal" is drastically different from its original easy-to-follow format/ layout. As a result of these numerous errors and clinical omissions listed above, the use of the article as currently published could adversely affect the care of patients and may result in injuries if not retracted and amended.

For the aforementioned reasons:

- We the undersigned medical practitioners, support a complete retraction of the article "An Urgent Care Approach to Fishhook Removal" (attached to herein in Exhibit A) in all media forms to mitigate or reduce risk to patients, ensure patient safety and satisfactory outcome.
- We the undersigned medical practitioners, support that an updated version of the article (attached to herein as Exhibit B) be published in the same edition or issue of the newspaper or periodical in which said article appeared and in as conspicuous place and type as said original article (both online and printed versions) in the Journal of Urgent Care Medicine.

By:  _____

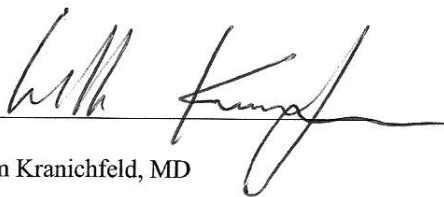
Virginia Sardinias, ARPN

Date: 9/8/2021

By:  _____

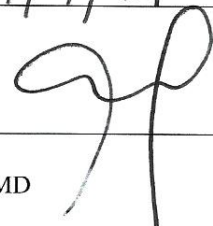
Markira Stewart, PA-C

Date: 09-08-2021

By: 
William Kranichfeld, MD


Medical Director Criticare Clinics Urgent Care

Date: 9/17/21

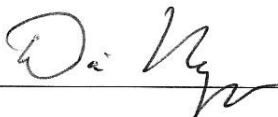
By: 
Ernesto Sanz, MD

Medical Director Criticare Clinics Urgent Care


Date: 9/17/21

By: 
Betty Ruiz, ARNP


Date: 09/17/21

By: 
Dia Nguyen, MD

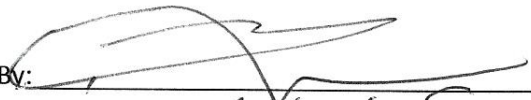
Date: 9/8/21


By: 
Yenny Ceballos, ARNP

Date: 9/8/21

By: 
Anisleydi Pardon, ARNP

Date: 9/18/2021

By: 
Name/Title: Michael Sason DO
Date: 09-08-21

By: 
Name/Title: Bonnie J. O'Sullivan MD
Date: 9/13/21

By: _____
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From: JUCM <forms@jucm.com>
Sent: Saturday, June 5, 2021 11:52 PM
To: swilliams@jucm.com
Subject: Journal of Urgent Care Medicine Contact Request

Name	Sheron Clarke
Email	sheronclarke2742@aol.com
Message	I am writing to you as nurse to say that there are multiple errors in your publication of Fishhook Removal. These errors can adversely affect the care of patients, which may result in more harm than good. For this reason ,I think a correction is imperative in order to mitigate or reduce risk to patients,and ensure patient safety and satisfactory outcomes.

<https://jucm.com>)



This email has been checked for viruses by Avast antivirus software.
www.avast.com